

Old Shenfield Place Ltd

Old Shenfield Place

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This comprehensive inspection took place on 25 July 2018 and was unannounced. Old Shenfield Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Old Shenfield Place provides accommodation and personal care for up to 31 older people. There were 17 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 manager was in post that had completed an application to register, this was confirmed during this inspection process. 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.'

At the last comprehensive inspection on 21 March 2017 the overall rating of the service was, Requires improvement. We found that there were three breaches of the regulations. This was because there were shortfalls in the arrangements that had been made to provide people with safe care and treatment. Risks to people were not always reflective of their current care needs, insufficient numbers of skilled staff were deployed to ensure people's needs were met at all times, and systems to assess, monitor and improve the quality and safety of the services were not effective.

We told the provider to send us an action plan stating what improvements they intended to make to address our concerns. After the inspection the provider told us that they had made the necessary improvements.

Whilst we found improvements had taken place in some areas, people remained at risk of unsafe care and treatment and the provider had not done enough to mitigate these risks. The rating of the key questions, is the service safe and is the service well-led, as well as the overall rating for this service, remains requires improvement.

During this inspection, we found the registered manager had not communicated with us openly or taken appropriate action to ensure that medicine errors reported to them had been dealt with in a timely manner.

This was a continued breach of Regulation 17 good governance.

At the last inspection on 21 March 2017 we found that people's risk assessments were not always reflective of their current risks and did not guide staff on how to care for people. At this inspection we found the provider had made the necessary improvements and risks to people were now well managed.

There were enough staff deployed to work in the service who had been suitably recruited. Training was

available for staff to ensure they had the skills and knowledge to provide effective care for people. Staff had received regular supervision and appraisals. The registered manager now had a good oversight of training and supervision.

There were procedures for safeguarding people from abuse and the provider worked with other organisations to investigate and respond to allegations of abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People gave us positive feedback about the quality of the food. They were provided with sufficient food and drink.

People received support from caring staff who gave people time to make choices and decisions. Staff treated people with dignity and respect. People were supported to maintain their independence. Relatives and visitors were made welcome at the service by staff who knew them.

People received care that met their preferences. People's past lives, cultural and diverse needs were assessed and reviewed to enable personalised care that met all aspects of people's needs. People had opportunities to participate in social activities, interests and hobbies that were meaningful to them.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

Procedures around the safe management of medicines needed to be improved to ensure people always received their medicines as prescribed.

People felt safe and risks to people health and care needs had been assessed and were managed.

Staffing levels were adequate to meet people's needs.

People were protected from the risk of infection by a clean environment and established systems to maintain hygiene standards.

Is the service effective?

Good 

The service was effective.

The service supported all staff through training, supervision and appraisal in line with the provider's policy.

People had consented to their care and treatment and the provider had followed the principles of the Mental Capacity Act 2005.

People were supported to have sufficient to eat and drink to maintain their health.

Is the service caring?

Good 

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

People's independence, privacy and dignity was promoted and respected.

Staff took account of people's individual needs and preferences.

Is the service responsive?

Good ●

The service was responsive

Care plans were person centred and reviewed regularly.

A range of meaningful activities were provided at the service.

People could contribute to the choices of activities.

People and relatives felt comfortable in raising complaints and concerns.

Is the service well-led?

Requires Improvement ●

The service was not always well-led in all areas.

Governance systems had been reviewed and changed. Shortfalls identified had not been responded to in a timely way.

There was a positive staff culture.

Positive feedback was received about the management of the service and the improvements being made.

The service had developed good links with the local community.

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 25 July 2018 and was unannounced. The inspection visit was carried out by two inspectors, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection, we spoke with eight people who were using the service and five family members. We also spoke with the operations manager, the registered manager, six members of staff and a healthcare professional. We looked at the care records of three people and records relating to care, staffing, medicine, health and safety and quality assurance.

Is the service safe?

Our findings

At the previous inspection in March 2017 we found risks to people's health and wellbeing were not consistently identified, managed and reviewed. We also found there were not always enough staff to meet people's individual needs. At this inspection these areas had improved. However, we identified people were not always supported with their medicines safely so this key question remains requires improvement.

There were arrangements in place to record when medicines were received into the service and given to people. Each person had a completed medicine administration record (MAR) which recorded the medicines people were prescribed and when to administer. The MAR contained a running total of medicines that were boxed rather than in a pre-packed system from the pharmacy. We checked the stock balances of medicines in the trolleys and found they were not always correct which meant staff were unable to account for them. We counted ten boxes of tablets, out of these, six contained the incorrect balance.

We found transdermal patches (used to treat some types of chronic pain) had been applied a day late for two people on the week before our inspection. We also found staff had signed twice for the same medicine for another person who was on respite. Whilst we found the balances confirmed the person had only received the medicines once, as staff had signed for these medicines twice we were not confident staff were following the correct processes when administering people's medicines.

Night seniors usually conducted the counts of boxed medicines and on one occasion a senior during the day had started the counts which led to some confusion. Gaps had been left in recording counts and this meant staff had not identified whether people had received their medicines or whether this was a recording error. When we looked at the audit documents we noted a pharmacy audit had been carried out on the 22 June 2018 and a manager's audit in the same month. This demonstrated up until this current month medicines were administered safely. We also looked at recent daily audits completed by senior staff and found some of the concerns we had found had been recorded.

We informed the registered manager immediately of the concerns we had found and they took immediate action. Whilst we noted these errors had not led to any harm for people involved, we identified the registered manager had not responded to these concerns in an open and timely manner. More information related to this concern is recorded in the well led section of this report.

Medicines were stored safely for the protection of people who used the service.

Since our last inspection the provider had taken steps to improve the process of identifying and assessing people's risks. Staff we spoke with described people's individual risks and how they kept them safe from harm. For example, one person walked independently and sometimes forgot to use their walking frame, the guidance stated if staff observed them walking, they should supervise without restricting their movement. We noted this person's falls had reduced.

Staff could describe how they kept people safe when they mobilised around the service and we saw

throughout the inspection staff supported people to move safely. Information about changes in people's needs were shared at shift hand over to ensure staff had up to date information related to risk.

At our last inspection in March 2017 people and their relatives felt at times more staff were required. At this inspection people told us there were sufficient numbers of staff to meet their needs. One person said, "I think they've been a little short staffed recently, but we all think they've coped well." A staff member told us, "It would always be nice to have more but seniors do help and we do meet people's needs." Another staff member said, "I think it works well, we are working as a team which is good." During our observations we observed staff responding to call bells in a timely way and communal areas were checked regularly.

People told us they felt safe. One person said, "Sometimes the staff are very busy, but they always answer the buzzer and they come in and tell us what they're doing and they may say they'll be back in 5 or 10 minutes – and they always are – they don't keep you waiting." A relative told us, "I'm very happy with the home. I'm taking [family member] out today, and I visit them most days. I think [family member] is safe in here and being looked after really well."

We looked at the recruitment records for three members of staff and found the necessary checks had been completed before staff began working at the service. This included an enhanced Disclosure and Barring Service (DBS) check, which is a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Proof of identification and references had been obtained for each member of staff. These checks helped to ensure the staff employed were suitable to provide care and support to people living at the service.

We looked at the arrangements for keeping the service clean and protecting people from the risks associated with poor infection control. Cleaning schedules were in place. Domestic staff were on duty during our inspection and we observed cleaning being carried out. The staff wore protective clothing such as gloves and aprons and disposed of these after single use. The provider undertook audits of infection control. Therefore, people were being protected by these procedures and systems.

There were systems to learn from when things went wrong. The staff recorded all accidents, incidents and complaints. The registered manager and provider's representatives analysed these to make sure appropriate action had been taken and to identify any trends. A service improvement plan was in place that recorded all information including what action had been taken.

The service had recently joined Prosper and additional information was being collected for analysis relating to falls and infections. Prosper is a collaboration between care homes, Essex County Council, the health sector, UCL Partners and Anglia Ruskin Health Partnership, designed to improve safety and reduce harm for vulnerable care home residents, who are at particular risk of admission to hospital or significant deterioration in their health and quality of life. It uses quality improvement methods to reduce preventable harm from falls, urinary tract infections and pressure ulcers.

Is the service effective?

Our findings

At the inspection in March 2017, we found staff had not completed all the training identified as mandatory by the provider. At this inspection of 25 July 2018, we found improvements had been made. The people we spoke with who lived at the service told us they were happy with the care they received and they felt staff had the knowledge and skills to meet their needs. One person said, "The staff are excellent. They are helpful, kind and I think they are well trained."

New members of staff undertook training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. They were given regular training updates and the provider had systems to ensure these were taking place. The staff we spoke with discussed the training they had undertaken and how this was helpful for them. One staff member said, "Training is mainly online with some practical training such as manual handling, first aid and fire marshal training but it is helpful."

The staff received support from the managers at the service and had opportunities to take part in team and individual meetings. They met with their line manager to discuss and appraise their work, and had the opportunity to undertake vocational qualifications or follow other career opportunities. The staff told us they felt supported. They said they were able to speak with the registered manager and seniors if they needed additional support.

The staff were able to demonstrate a good knowledge of the people who they were caring for and their roles and responsibilities. They told us about people's individual needs and also knew about different healthcare conditions and the type of support people required regarding these. The staff explained they had written information and took part in daily handovers where they discussed the service and changes in people's needs.

People's needs were assessed and they had care records developed when they came to live at the service. Staff were aware of people's needs and risks and were able to explain the support they needed to meet them. Information was recorded in people's care records and where required specialist advice was sought to assess people's needs and develop care records and risk assessments. People had regular access to healthcare professionals and staff were vigilant to changes in people's health. A healthcare professional told us, "This is one of the better homes, there are usually staff around and they are pro-active when we offer advice or guidance."

People told us they enjoyed the food at mealtimes. One person said, "I've found the food is fine here, there's always an alternative if you want something else." We saw plans were in place that detailed the support people needed to ensure their nutritional needs were met. For example, people who had been assessed as a high risk of malnutrition had a care plan in place that detailed the actions required by staff. We saw these people were encouraged and assisted throughout mealtimes as stated in their plans of care. Staff completed food and fluid intake charts to monitor the amount people ate and drank which ensured people received sufficient amounts to meet their nutritional needs to keep them healthy. This meant people were

supported to eat and drink sufficient amounts in line with their assessed needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Where people lacked the capacity to make decisions about their care, mental capacity assessments had been completed and their relatives had been involved in best interest decisions in line with the MCA. Where people needed to be deprived of their liberty to keep them safe, appropriate applications for authorisation had been submitted to the local authority. Records showed most staff had just completed an MCA/DoLS workshop in April 2018. We saw staff consistently gave people choices and asked permission before providing any care or support.

We found aids and adaptations available to meet people's needs and enable them to remain as independent as possible. Bathrooms had been adapted to accommodate people who required support from staff and there were hoists available. The service had a very comfortable, homely feel with doors from the conservatory leading down into lovely gardens. We saw people and their family members sitting in the shade having a chat.

Is the service caring?

Our findings

At the last inspection in March 2017 we rated this key question good. At this inspection the service remains good.

People told us staff had a caring attitude and approach. One person said, " They are so lovely here; that's all I want to tell you. [Named staff member] has a heart of gold and has time for everybody." We observed staff treating people with kindness and dignity.

People's choices in relation to their daily routines and activities were listened to and respected by staff. We observed lovely warm interactions between all care staff and people. Staff used touch appropriately to comfort and show kindness to people, holding hands and stroking people's faces. We observed people given choice, engaging with staff and each other with friendly banter.

Staff understood the importance of promoting equality and diversity, respecting people's religious beliefs, their personal preferences and choices. For example, staff supported people to maintain personal relationships with family members and friends. This was based on staff knowledge of the person, what was important to them, their life story and background.

Special events were organised throughout year to support people to access the wider community and maintain important relationships. For example, family film afternoons took place where children's films were shown so grand children could watch films with their grandparents. Relatives and people from the community were also invited to special events such as barbecues and afternoon tea to promote social inclusion. Church services were held every four to six weeks to meet people's spiritual needs. A relative told us, "This is such a nice home, and we're so very pleased [family member] is here and being well looked after. It really does feels like home when you come in. I drop-in very regularly, it's always friendly, the staff are lovely and we see the manager around a lot, she's nice to talk with."

People told us their privacy was respected. They said staff addressed them by their preferred names and knocked on bedroom doors. We saw this to be the case. The staff spoke with people in a respectful way. Staff promoted people's independence and people were observed to walk independently around the service. A staff member said, "[Named person] comes down to eat but gets anxious and wants to go back to their room. I saw them get piece of paper out of their wallet, it was written on where they live and their room number, I think they were anxious about becoming lost; I have since made them a plastic credit card with the information on they can keep in their wallet, its smaller and easy for them to access."

Staff spoke about the range of ways they communicated with people. One staff member told us, "We have printed out some symbols in [named person's] room, and given them enough time so they can point to them to express their needs. We also use 'wiggle your toes' which has been really effective. They also really like their sensory pillow, it changes colour at night and they love music and looking at emails from family. I read them and we look at the pictures together."

We observed this staff member using this communication with the person, they asked simple yes no questions and got the person to wiggle their toes for yes. This was an effective means of communication. For example, "Would you like a sip of your tea." Person wiggled toes. Staff held beaker to mouth and gave person a drink then said, "Wiggle your toes if you would like some more." They kept repeating until the person had enough to drink. These examples demonstrated the service was meeting the Accessible Information Standard where they identified, recorded, flagged, shared and met people's needs.

Is the service responsive?

Our findings

At our previous inspection we rated the service requires Improvement in responsive because care records did not always contain sufficient up to date information or guidance required. At this inspection we have rated the service as good in responsive, as the provider had made a number of improvements to care records.

Care plans gave information regarding people's background and history. This included 'What's important to me' and gave detail of life history, talks about family, life experience, work, hobbies, interests and likes and dislikes. For example, one care plan stated, "[Named person] attends Parkinson's movement to music weekly – [named person] enjoys this as their favourite activity is dancing. This care plan also emphasised the importance of choice and control and recorded, "[Person] can eat independently and cut up their own food, give [person] the daily menu so they can choose their own meals, they like to eat in the dining room as they enjoy social interaction." In another care plan the person did not like loud noises. This type of information enables staff to deliver care personalised to people's wishes. Care plans were reviewed regularly and updated to ensure people's views and decisions made were documented.

Although the staff team was not supporting anyone at the end of their life at the time of our inspection, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their care plans. Staff had received training in this area and a local hospice offered advice and support to the service when they were caring for people at the end of their life.

The service had recently employed a new activity organiser and their impact on this area after only a few months was excellent. People were very positive about what was on offer. One person told us, "It's lovely here. I get out on trips and the garden is lovely to get out into. There's lots to do, and I enjoy the quizzes." Another person told us, "The activities lady is simply superb – they have some really splendid ideas and it's a lot of fun." A third person said, "We have a nice young man come in and he give us some exercises to do, and I really feel I've done some exercises when he leaves – I really look forward to him coming each week."

During our visit we observed a music activity. The activities person turned to a person and said, "Would you like to play songs from the Avene?". (This was French music which the person had requested previously, the activities staff member had added it to their music play list and remembered what the person liked) They [the person] said, "Yes please." Then said, "The music is lovely." Another person requested Irish music which was then played, the person smiled, closed their eyes and tapped their foot, clearly enjoying the music. The activities person worked the room including everyone. They went to a person who had just woken up and asked, "What would you like to hear?" When they got no response they prompted, "How about Patsy Kline, you love her, I will play it and sing to you." They played the music then went and sang holding person's hand saying, "Shall we have a little dance." The person was awake and engaged and smiled at the interaction.

The activities programme was structured around what people had expressed an interest in doing. It might change according to people's preferences. For example, an exercise class was cancelled because it was hot so they listened to music instead. Activities were adapted to meet people's cultural needs and the activity

staff member told us during a sausage tasting activity, one person was a vegetarian so they bought veggie sausages so they could be included.

There was a newsletter which was people led. It included pieces people had written. The activity staff member said, "It's a team effort." When the new garden was planned there was a group discussion so everyone was consulted. People had chosen the design and which flowers were to be planted. People were supported to access activities outside of the service. For example, one person was invited to a wine club in the evening. Activities staff accompanied the person so they could attend. People attended a tea dance twice a month and shopping trips and pleasure trips were arranged.

There were systems and processes in place for people to provide feedback and to deal with, and address complaints. People and their families told us they would feel comfortable telling the staff if they had any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to their manager. Staff told us they were confident the registered manager would act upon complaints appropriately. There was a procedure available which detailed how people could make a complaint. We reviewed records of complaints and found these had been investigated and responded to in a timely manner.

Is the service well-led?

Our findings

At the last inspection in March 2017 we found 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. This was a breach of the legal requirements. Whilst we saw overall quality assurance processes had improved, we found appropriate action had not been taken by the registered manager when concerns relating to medicines were brought to their attention. In addition, we found that the registered manager had not been open and transparent with us when we raised the concerns about medicine administration.

Initially when we raised our concerns about medicines to the operations manager and registered manager we were told they were unaware of these concerns as the senior staff had not brought these to their attention. The manager responded immediately by taking appropriate action to investigate these concerns, in line with the providers policy.

Unfortunately, we then received information from a whistle blower that stated the registered manager had been informed about these errors two days before the inspection. In further correspondence the operations manager confirmed that the registered manager had received a verbal report of errors relating to stock balances of medication two days prior to the inspection. However, they not completed their investigation at the time of the inspection.

Medication errors involving the administration of transdermal patches had been reported to the registered manager the afternoon before the inspection however no action had been completed at the time of the inspection. This failing to act immediately could potentially have put people at risk of not receiving their medicines in line with the prescriber's instructions.

This was a continued breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found records relating to people's care were kept up to date and accurately reflective of people's needs. The registered manager had re-organised records which made important information about the service easy to find and accessible. Routine maintenance and servicing records such as hoists and records relating to staff and the running of the service were kept up-to-date. Staff understood the need to maintain confidentiality and to keep people's information safe.

People, their relatives and staff told us they felt the service was now well-led. One person told us, "It's all good here. Lovely people, we're really well looked after. No problems." Another person pointed out the registered manager and said, "This is our new manager, they are lovely. They are always around and chatting with us." A staff member said, "It's good here – it's very friendly, nice staff and everybody is well looked after." Another staff member told us, "The manager is very approachable and asks how we are feeling." A third staff member said, "Care is very good here and I would absolutely have a relative living here."

People's views about the quality of care were sought regularly, talking with people and their representatives

and at resident/relative meetings. Meeting minutes looked at confirmed this. Where comments had been made the provider had responded to them and the actions taken had been recorded. For example, the activity staff member showed us a 'you asked' – 'we did' sheet, which showed the service had responded to requests from people for family film afternoons, fresh fruit and more group outings.

Regular staff meetings were held. The meeting minutes confirmed staff received updates, had the opportunity to raise concerns, share ideas around good practice and learn together from any outcomes to investigations or complaints.

Records showed the provider continued to work in partnership with other agencies to ensure people received the care they needed.

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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and process required improvements, as timely action was not taken when shortfalls were identified.