Mr & Mrs S Arithoppah

Sheldon Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 5 March 2016 and was unannounced. The last inspection took place on 13 June 2013 and no breaches of legal requirements were found at that time.

Sheldon Lodge provides care and accommodation for up to nine older people. Some people living in the home had mental health support needs and some were living with a form of dementia or cognitive impairment. At the time of our inspection there were nine people using the service.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were sufficient staff numbers to enable them to perform their roles effectively during our inspection and the rota that we viewed. However some staff told us occasionally they could do with another member of staff at busy times, we discussed this with the provider and the staff on duty. The provider confirmed they lived and so worked every day in the home. They also confirmed staff called them when extra help was required. The provider agreed to discuss this with the whole team at a team meeting to reinforce their availability.

The provider had ensured that staff had the knowledge and skills they needed to carry out their roles effectively. Relevant training was provided to ensure staff's knowledge was up to date.

Staff understood people's individual needs and their daily routines. Care was delivered to people in a person centred way.

People's rights were protected in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's capacity was considered in decisions being made about their care and support and best interest decisions were made when necessary. Staff received training to help them understand their obligations under the Mental Capacity Act 2005 and how it had an impact on their work.

We found the provider had systems in place that safeguarded people. Policies and procedures were in place to guide staff to make referrals to the relevant external agencies if the need arose. Staff we spoke with demonstrated an understanding of the process.

Safe systems were in place to safely manage people's medicines. A policy was in place to guide staff through the process of ordering, stock control and the disposal of any unused medicines. Staff also received regular training in this area to ensure they were competent to administer people's medicines.

People were involved in reviews of their care needs to ensure that staff had up to date information about

how to meet people's needs. People's records demonstrated their involvement in their support planning and decision making processes. One person we spoke with confirmed their involvement in the process and how staff respected their wishes.

Support plans and risk assessments were representative of people's current needs and gave detailed guidance for staff to follow. Staff understood people's individual needs and preferences which meant that they received care in accordance with their wishes.

People, relatives and friends that we spoke with told us people received a good quality of care and support and felt welcomed when they visited the home. People were supported to maintain relationships that were important to them.

Staff we spoke with felt the service was well led and the registered manager was available and visible in the home. Staff meetings took place on a regular basis. Minutes were taken and any actions required were recorded. Staff felt they worked well as a team and responded to the direction of senior staff.

Quality and safety in the home was monitored to support the registered manager in identifying any issues of concern. There were systems in place to obtain the views of people who used the service and their relatives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had arrangements to respond to suspected abuse. Staff received training in safeguarding adults and a clear policy was in place for staff to follow.

Safe recruitment processes were in place. Appropriate checks were undertaken before staff started work in the service. Sufficient numbers of staff were on duty to meet people's personal needs.

Risks to people's safety were assessed before they came into the service. Every person had general risk assessments in relation to the environment and going out in the community. They also had individual ones related to their individual care needs.

Staff who administered medicines were given training and medicines were given to people safely.

Is the service effective?

Good

The service was effective.

People told us staff understood their needs. We observed this during our inspection and staff were attentive.

People received co-ordinated care. We saw evidence in people's care plans that demonstrated people had been visited by their GP and other health care professionals.

People received care from staff who had received training that enabled them to carry out their roles.

Staff received regular one to one supervision and records showed that the sessions were used as an opportunity to discuss staff performance and development needs.

People's rights were protected in line with the Mental Capacity Act 2005 and staff received training in this area.

People's nutrition and hydration needs were met and meal

choices were offered to people. People's nutritional care plans were clear and detailed.

Is the service caring?

Good

The service was caring.

People we spoke with told us staff were caring and sensitive to their needs.

People were supported to maintain links with their families and friends. Visitors were made welcome in the home and comments we received were positive.

People and their relatives were involved in decisions about their care and support. This was clearly demonstrated within people's care records.

People's opinions were sought and people were able to make comments about the service. Residents meetings took place on a regular basis.

People's spiritual wishes were considered as part of the assessment process. People could have access to places of worship in line with their wishes.

Is the service responsive?

Good

The service was responsive.

Staff understood people as individuals with their own preferences, likes and dislikes.

Care files were comprehensive in content. Information included; personal background information, likes and dislikes, individual support plans for all activities of their daily living needs.

Personalised care and choice was offered to people that used the service. Care plans were developed with people and people signed to say they agreed with what was written.

Where people may present with behaviours that could potentially affect others, there were individual plans in place to guide staff in managing this.

There were arrangements in place to respond to complaints. A complaints policy and procedure was in place.

Is the service well-led?

Good

The service was well led.

People told us the provider was visible in the home and approachable.

Staff said the service was well-led and the provider was approachable, supportive and took action swiftly to any concerns.

Systems were in place that ensured incidents and accidents were reviewed and monitored.

The provider had a system in place to monitor and audit the quality of the service. This included regular audits undertaken by the provider.

People's opinions were sought on a daily basis and also in a yearly satisfaction survey.

Sheldon Lodge

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 the 5 March 2016 and was unannounced. The inspection was undertaken by one inspector. Prior to the inspection we looked at all information available to us. This included looking at any notifications submitted by the service. Notifications are information about specific events that the provider is required to tell us about.

As part of our inspection we reviewed the care records for three people living in the home and also looked at staff records to see how they were trained and supported. We spoke with people and their visiting relatives and also made observations of the care people received in the communal areas. We spoke with two members of staff and the provider who was also the registered manager. We looked at other records relating to the running of the home which included audits, staff supervision and training records and meeting minutes.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home and some people were able to tell us they understood what to do if they didn't. One person told us "I would tell anyone here if I didn't feel safe. They are all very nice".

Staffing levels were suitable to meet people's needs of people during our inspection. The registered manager told us two care staff were always on duty during the day and a domestic worked Monday to Friday. The registered manager said "we also work Monday to Friday but we are not written on the rota. [Name] cooks the breakfast and I cook the lunch. I will do whatever needs doing supporting people and washing if needed. We are here to work, most days four of us are on duty. We live here so that's what we do". We discussed the process if someone was unwell. The registered manager said "I will put extra staff on as needed. We rarely go away so we are always here this is our life we have been doing this safely for 20 years". We discussed a comment we received that sometimes only one person was on duty. They explained there was one staff vacancy and on occasions between 3pm and 4pm there had been a shortage in cover. However they said "we are here to cover this and if we are not in the immediate area staff know to call us down and we respond". The registered manager stated they were the sleep in cover for the home and began checks after 11pm on people's welfare and the emergency call bell was in place if people needed to summon help. They said "I go around at regular intervals and check the TV's are off, and people are ok. It's been the same for 20 years. If I go on holiday I put a member of staff on duty to cover this duty". People confirmed their night time needs were met. We discussed with the registered manager that the rota should depict what staff were actually working. Therefore if they worked regularly they should show this on the rota, so staff and people would know who was working.

Safe recruitment processes were in place. Appropriate checks were undertaken. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks were undertaken. Staff we spoke with and the staff files that we viewed confirmed this.

The registered manager had arrangements to respond to suspected abuse. Staff received training in safeguarding adults and a clear policy was in place for staff to follow. Staff we spoke with had a good understanding of what constituted abuse and who to report concerns to. Staff understood what whistleblowing meant and the provider had a policy in place to support staff who wished to raise concerns in this way. Whistleblowing is a route staff can use to raise concerns they may have with staff behaviour or practice concerns. One member of staff said" Oh yes I do know the policy and would have no worries at all about reporting. I would tell [name] immediately if I had any concerns. That's what it's for".

Risks to people's safety were assessed before they came into the service. Every person had general risk assessments in relation to the environment and going out in the community and then had individual ones related to their individual care needs. Risk assessments that we viewed contained detailed information to guide staff to meet people's individual needs and also promoted their independence. For example one person's documentation in relation to their short term memory stated "remind [name] of time and place at

all times prior to activity to encourage interaction". Other people's bathing assessments balanced the risk presented with the person's independence.

Staff who administered medicines were given training and medicines were given to people safely. Medicines were recorded and records detailed what medicines were prescribed and how and when it was administered. Medicines were stored safely and appropriately. A sample of stock was checked and matched with the records that were held. Records showed all staff were trained in medicine administration and regular competency checks were undertaken by members of the senior team to monitor their skills. The registered manager also undertook a monthly audit to ensure people had received all their medicines in line with their prescription.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The registered manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up and support plans adjusted accordingly.

Maintenance, electrical and property checks were undertaken to ensure they were safe for people that used the service. These checks included: six monthly environmental checks, fire alarms three monthly, portable appliance testing yearly and food safety checks weekly. The provider told us actions plans would be compiled and actioned accordingly. Regular fire alarm testing took place to ensure all staff were aware of the procedure in place and policies were in place to support this.

Good

Is the service effective?

Our findings

People told us staff understood their needs. One person said "they understand me very well. The best companionship I've ever had". We spoke with two care staff who were very knowledgeable about the likes and dislikes of the people they supported. We observed that staff were respectful towards people and very attentive to their needs. For some people who were not able to verbalise fully, we saw that care staff understood their cues and the meaning of their interaction with them.

People received co-ordinated care. We saw evidence in people's care plans that demonstrated people had been visited by their GP and other health care professionals. For example, people's files held information in relation to the advice sought from the community psychiatric nurses. People were visited by their social worker and other professionals when there was a change in their needs and support plans were adjusted to reflect the advice that was given. We saw information that supported joint working. This included joint assessments before people came into the service and subsequent reviews. The registered manager told us "we do have good working relationships with the community teams and can get referrals actioned swiftly". The registered manager also described the process that recently took place to support a new person into the service. The joint working ensured an effective placement for the person took place and reduced the risks of it being unsuccessful. This was because they shared important information and assessments, that ensured the service could meet the person's individual needs.

People's on-going health needs were managed and people were supported to attend their GP and other medical appointments when required. People's documentation that we viewed confirmed this as did one person we spoke with.

People received care from staff who had received training that enabled them to carry out their roles. Training included: equality and diversity, safeguarding adults, infection control, MCA, Dols and specialist training related to people that lived in the home. For example mental health and epilepsy. Staff also completed further development training such as NVQ2. The provider confirmed only three staff had not yet completed this. Staff told us "it's good here. Enough training for me and I always feel supported when dealing with certain behaviours people can exhibit because I have training in this area".

Staff received regular one to one supervision and records showed that the sessions were used as an opportunity to discuss staff performance and development needs. Staff also reported that they would feel confident approaching senior staff or the registered manager at any time on an informal basis to discuss any issues or concerns. All staff also had a yearly appraisal. The registered manager said "this is time for us to go through development and training they have undertaken and what might need to be completed". they also said "I am working on the floor all the time so I can see if practice is good enough and checks staff competency all the time. Training in certain areas can then be provided instantly".

Volunteers visited the service. The registered manager told us how a couple of students from a local college came to the home as part of their 'duke of Edinburgh award scheme' some time ago and continued to visit. They described how people valued their visits and the one to one time they enjoyed to sit and chat about

their interests and lives.

People's nutrition and hydration needs were met and meal choices were offered to people. People's care plans were clear and detailed. For example, one person needed staff to support them with their eating and drinking at all times. The observations we made during our inspection were in line with their assessed needs. The registered manager competently discussed ways they encouraged people to eat regularly and promoted independence. For example, one person due to their dementia ate at different times of the day and the service ensured finger foods were available to encourage people to eat when they wished to. The registered manager told us "we know how people wish to eat and when. We are a small home and we can have this knowledge and flexibility for everyone". Choice was also available for people as were snacks and drinks any time they wished. People's nutritional intake and weights were monitored as required and specialist advice was sought. The registered manager described how pictures and flash cards were used to prompt people's memory in order to help them be involved in their menu planning.

People's rights were protected in line with the Mental Capacity Act 2005.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 legally authorised under the MCA. We saw examples of best interest decisions being taken on behalf of people, where it had been assessed they did not have the capacity to make specific decisions. Documentation contained details of who was consulted and involved in the decision making process. The assessment clearly identified the day to day decisions the person could make independently and the support required for more important decisions that may need to be made. For example in relation to major surgery that was being offered.

Staff confirmed they had received training in the Mental Capacity Act 2005. Staff were able to tell us about key aspects of the legislation and how this affected people on a daily basis with their care routines. Staff were heard routinely asking people for their consent throughout the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLs). A process was in place and staff were aware what this meant. If a person needed to be deprived of their liberty in order to keep them safe and it was in their best interests to do so, a process was in place to make an application to relevant authority for Deprivation of Liberty Safeguards (DoLS) authorisation. Documentation that we viewed confirmed applications when made, were followed up appropriately.

People's rights were respected. One person's file documented their 'do not attempt resuscitation' (DNAR) wishes had been clearly documented and signed by the individual that demonstrated their involvement. Staff were also reminded of people's basic human rights. A notice displayed in the office area depicted the basic human rights principles. The registered manager said "I often ask staff can they be sure they adhere to this [pointing to the notice board] on a daily basis. It just reminds them. If not why not, as we all must do this".

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring and helped them with their daily routines. Comments included: "like a family to me", "lovely staff" and "they are very good here couldn't wish for better". The registered manager told us "we have good family relationships here it's like an extended family for everyone. People's relatives speak to everyone when they visit". Relative comments included: "My [name] is always smiling and happy a high standard of care is given" and "staff are caring and approachable. A family environment".

People were supported to maintain links with their families and friends. We were told people could have visitors throughout the day in the home with the agreement of the person. People and their relatives we spoke with confirmed this.

People and their relatives were involved in decisions about their care and support. This was clearly demonstrated within people's care records and support planning documents that were signed by the person wherever possible. The registered manager also described how they communicated with relatives when people's needs changed or if they required to purchase equipment or personal items. Various methods were used such as telephone and email contact. This was observed during our inspection.

We saw that staff showed patience and gave encouragement when supporting people. We saw people looked relaxed and engaged in their own environment. We observed one person helped staff to set out the dining tables and staff confirmed they liked to do this. The person looked relaxed and responded happily when staff chatted to them and gave guidance. People were allowed time to make their choices using communication methods in line with their individual assessed needs. We observed this during the meal time activity.

Some people were happy for us to speak with them in their rooms. We observed that people in their rooms were comfortable and had access to their call bell. Each room was personalised according to their interests and personal memorabilia. The registered manager discussed how they didn't like the use of name badges on doors. They said "I prefer to remind people of their rooms with things that interest them. For example, a football badge of the team they follow. It's much more sensitive and ordinary".

Staff had a good knowledge of people's likes and dislikes. Staff and the registered manager were able to describe people's routines and how they liked to spend their day. This was observed during our inspection as staff gave reassurance to a person that became agitated. Staff reassured them and offered them a walk in the garden that reduced their anxiety.

People's privacy and dignity was respected. Staff knocked on people's doors before entering during our inspection and asked for if it was ok to enter. Care was provided behind closed doors and the member of staff asked the person if they were happy to undertake the particular activity.

People's opinions were sought and people were able to make comments about the service. Residents

meetings took place and the registered manager told us they sat with people during meal activities and asked them how they were feeling about things. They told us "we gather a lot of informal feedback. I need to consider ways to capture these conversations on a more formal basis".

As part of the provider's quality monitoring, people's views were also sought through surveys on a yearly basis. Surveys were sent to people, their relatives and external professionals. Comments received June 2015 were positive and the registered manager told us they would talk through any comments that would be made with the individual people.

Spiritual wishes were considered as part of the assessment process and people could have access to places of worship conducive with their spiritual following and some people received visits from their spiritual leaders as they requested. The provider also told us how on a Sunday some people liked to watch a particular program on the television and enjoyed singing along to the hymns.

End of life discussions and decisions took place in line with people's individual wishes. We were told when people settled into the home they would be asked their wishes. Should they not wish to discuss it their choice to do this would be respected. End of life care plans were in place for people who required it and the home worked closely with the community nurse team and the persons GP. We saw evidence in a person's file that demonstrated how they were supported through this process.

Advocacy information was supplied to people and documentation in their care files showed it was explained to them and people signed this documentation if they were able to. This demonstrated people were given information to support their future needs.

Good

Is the service responsive?

Our findings

The service was responsive. Staff understood people as individuals with their own preferences, likes and dislikes. Staff we spoke with demonstrated their understanding that was in line with the documentation that we viewed. Staff said "[name] can't always verbally say what they want but we know them well and can see the time they fall asleep at night in the lounge. We use this as a gauge to their night time routine. We know people so well because we are a small home we have the time to sit and observe people's routine wishes".

People's support needs were assessed before they came into the service. Assessments were supplied by people's social workers and wider professionals. However the registered manager confirmed they always undertook their own assessment to ensure the information that was provided was correct and had not changed and that they could effectively meet the person's needs.

The home kept a record for each person of all correspondence from care and health Professionals who were involved in their care. The record detailed people's treatment, any recommendations and follow up review dates.

Care files were comprehensive in content. Information included; personal background information likes and dislikes, individual support plans for all activities of their daily living needs. Care plans were reflective of people's current level of need. This was clear from our observations that we made. This ensured there was consistent guidance in place for staff to follow. Care plans included: Moving and handling, health, nutrition, preferences, likes and dislikes, night and day routines and mental health. Care plans were evaluated on a bi monthly basis to ensure they were current and reflected any changes in the type of support that people required. The registered manager told us every six months people's care plans were totally rewritten.

Personalised care and choice was offered to people that used the service. Care plans were developed with people and people signed to say they agreed with what was written. For example one person's documentation recorded "I have read my care plan and I am happy with it".

People's bedrooms were well furnished and people were encouraged to personalise their rooms with photographs and memorabilia from their previous home. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

Where people may present with behaviours that could potentially affect others, there were individual plans in place to guide staff in managing this. These plans described the situations that may trigger these behaviours and how staff could support the person at these times. One member of staff told us they felt information was clear and training was supplied to help them support people in this way.

We saw evidence within the care records that the home had requested the involvement of other agencies when required. For example, detailed information from the speech and language therapy team (SALT) was available that detailed guidance in relation to people's nutritional needs. Detailed information and reviews also took place with the community mental health staff. This ensured when new people used the service

their mental health needs were checked and monitored, to ensure the service could still meet the person's needs. The registered manager confirmed the external health teams were responsive to people's changing needs and would respond to any referrals swiftly.

There were arrangements in place to respond to complaints. A complaints policy and procedure was in place and this identified other organisations and agencies that concerns could be reported to if necessary, this included the contact details of the Care Quality Commission. Records of compliments and complaints were kept and this helped the registered manager know what was going well in the service and any areas that required improvement. The log that we viewed was blank and the registered manager confirmed that no formal complaints had been received in two years. The registered manager said "if people have any concerns they see me any time as I am around all the time". People we spoke with and their relatives knew how to make a complaint.

Activities were arranged according to people's needs. Some people accessed their local community independently and some people attended a local daycentre. One person went on holidays independently and had electronic equipment to fulfil their interests and hobbies. The registered manager told us activities were provided in the home each afternoon. Activities included: nails and beauty, flower arranging, pizza making and baking. The registered manager said "I like staff and residents to come up with ideas. This helps the ownership of the activities. One member of staff likes to do a movie night with drinks and popcorn on their night to work and another will arrange afternoon tea parties with china crockery and fancy cakes". However these activities were not formalised in a timetable. But photographs were available of such activities. The provider told us they would consider formalising the timetable to help inform people what activities were planned and when.

Good

Is the service well-led?

Our findings

People we spoke with told us the service was well led and they knew who the provider/registered manager and senior staff were. Comments included: "they are really good here and [name] is around the home and lives here so I see them a lot". Staff we spoke with said "[name] is very approachable and will action any concerns" and "no waiting for action with [name] it's immediate".

There were systems in place to monitor the quality and safety of the service provided. There was a regular programme of audits in place. Checks included: medication, staffing, care planning, environment, cleaning and infection control, fire and equipment and concerns/compliments. These checks were undertaken by both the registered manager and their staff. There were also checks in place to ensure the safety of the environment. A five year maintenance plan was in place and depicted that for 2016 the areas for refurbishment were, the stairs, corridors and bathrooms. We noted during our inspection to the registered manager that some of these areas required updating. The plan also showed extra works that had been undertaken that was unplanned during the year. The provider said "we then will start all over again in 2017 with the re decorations program. It's a continual cycle".

Regular feedback from people who used the service, their relatives and professionals was gathered to help develop and improve the service. This was gathered during care reviews, resident meetings and yearly questionnaires. The registered manager told us told us they valued people's feedback and would respond individually to any comments from people, to ensure they felt listened to by the management team. The service had introduced a 'feedback tree' in the dining area. People were invited to write their views on a comment card and tie it to the tree. This was another method of people and staff being able to leave feedback and ideas for the provider to consider as part of the service development. While not everyone would be able to use this method, the registered manager told us staff as part of their daily routine, they would ask people for feedback and could arrange to tie a comment to the tree for them.

The registered manager communicated with staff about the service and staff were encouraged to give their feedback. This included regular staff meetings. the provider said "we ask staff for their opinions. If they feel something might work better then we would try it". During our inspection and discussions, a member of staff suggested to the provider some less experienced staff may benefit form extra training. The provider responded positivity and said "yes we can arrange extra care plan training and manual handling training. Extra training is always a good idea".

Accidents and incidents were monitored on a monthly basis as a means of identifying any particular trends, patterns or lessons to be learnt in the types of incidents occurring. The registered manager was aware of the responsibilities associated with their role, for example, the need to notify the Commission of particular situations and events, in line with legislation in the form of a notification.

The registered manager kept up to date with changes in the law and various pieces of legislation. They were fully aware of CQC's fundamental standards and changes in the way inspections now took place. We viewed notices on the office notice board the provider had developed in relation to CQC inspection key questions

and the basic principles to remember in relation to people's human rights. The provider said "it's useful to ask staff if they feel we are doing all of this. If not why not and it must change".
The registered manager was aware of when notifications had to be sent to CQC and had submitted these as required. These notifications would tell us about any events that had happened in the home. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.