Borough Care Ltd

# Shepley House

## Inspection report

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Date of inspection visit:
04 October 2016
05 October 2016

Date of publication:
17 January 2017

## Ratings

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| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 4 October 2016 and was unannounced. This meant that the provider and staff did not know that we would be visiting. We carried out a further announced visit on the 5 October 2016 to complete the inspection. We last carried out an inspection in October 2013, where we found the provider was meeting all the regulations checked at that time.

Shepley House is situated in a residential area of Hazel Grove in Stockport. It is a purpose built with accommodation spread over two floors. The home is registered to provide accommodation and personal care for up to 43 people. At the time of the inspection, 42 people were living at the service, some of whom were living with a dementia related condition. Some bedrooms have ensuite facilities. There are communal areas, including a range of lounges, dining areas and a large garden for people to use which has a summer house situated at the centre and is used for a variety of activities. The provider informed us that the service is earmarked for a major transformation/refurbishment by the local authority, who owns the building, by the end of 2020.

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

We found concerns with the safe administration of medicines. Staff did not always follow safe working practices or followed correct procedures. For example, we saw two staff members in different parts of the service administer medicines to people without waiting to check they had taken their medicines. When we checked people's records we found that no person at the service self-administered medicines, so this should not have occurred. We also found medicines trolleys were not always locked when not in use and medicines administration records were not always fully completed.

There were processes in place to monitor and review the safety and general maintenance of the premises. However, we found a number of safety issues with the premises and safe working practices. Upper windows did not have restrictors, to limit their opening that met with current Health and Safety Executive guidance. We found a number of products, including cleaning materials that were not locked away or supervised when being used, particularly in relation to the dementia unit. This meant there was a potential for people to be harmed.

We spent time in various parts of the service, observing care. At times, staff levels were not sufficient to meet people's needs fully. The registered manager told us that she used her experience of working in care to assess the number of staff required and did not use any monitoring tools, meaning we could not be sure appropriate levels of staff were always available. Following our inspection, the manager told us that she was now completing a new form to enable an assessment of staffing levels which would show that they were staffing the home with suitable numbers of staff. She also said she had been given confirmation that more

staff could be employed on the dementia unit in particular.

People said they felt safe living at the home and said the staff treated them well. Staff had received training regarding safeguarding and the protection of vulnerable adults. They said they would report any concerns to the registered manager.

Staff told us they felt supported and well trained and we confirmed that staff supervision had taken place regularly and training was up to date. We noted, however, that staff had only started to receive an appraisal in this current year having not received one previously with the provider. Not all appraisals were completed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. We found the provider was complying with its legal responsibilities, but records were not always in place to confirm this.

People were able to enjoy enough food and refreshments to meet their needs and if people needed additional support from staff, this was provided. Special dietary needs were also catered for. People were supported to access a range of health care professionals. Examples included appointments with their GP and visits to hospital for any emergencies arising and also scheduled appointments with specialist practitioners.

People were clean and appeared comfortable. Staff spoke compassionately with people and treated them with respect, and also promoted choice and independence. When a person was distressed staff supported them skilfully with warmth and kindness.

A range of audits and checks were completed at the service. The provider also completed quality monitoring checks and health and safety audits. We found, however, that the issues we had found during our inspection, had not always been found during these audits or had been found and appropriate action not taken. For example with regard to addressing the issues with the management of medicines and fitting window restrictors.

We have made two recommendations in connection with respecting people's belongings and DoLs authorisations.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe care and treatment, staffing and good governance. 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.

Safe procedures were not followed in relation to the management of medicines.

The provider had not always mitigated against all potential risks at the service, including in relation to window restrictors and chemicals used at the service.

People were protected from abuse and the staff knew and understood the whistleblowing and safeguarding procedures.

Management at the service followed safe practices for recruitment of staff.

### Is the service effective?

**Requires Improvement**

The service was not always effective

Staff received regular supervision and attended team meetings, although appraisals were only just being completed.

The feedback we received from people, relatives and visiting healthcare professionals was positive about the effectiveness of the service and reflected that staff were proactive in meeting people's needs.

Meals were suitable to meet people's needs and preferences.

### Is the service caring?

**Good**

The service was caring

People were treated with kindness and compassion, and told us they felt respected. Care was provided whilst maintaining people's dignity and respecting their right to privacy.

We saw positive interactions between people and staff.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People told us the service was responsive to their needs and care plans reflected people as individuals and were very person centred. Details in care plans, about how staff should support people, were not always clear or specific. Plans were reviewed and updated as people's needs changed.

There was a range of individual and group activities available to people and they were supported to maintain social interactions with friends and family.

## Is the service well-led?

**Requires Improvement**

The service was not always well led

The registered manager and provider regularly undertook checks to ensure people's care and the environment of the home were monitored. However, these checks had not always identified the items noted at the inspection.

Records were not always appropriately maintained and stored to ensure security and confidentiality.

Professionals told us the home was responsive to any issues they highlighted.

People, relatives and staff knew who the registered manager and deputy manager were and felt they could approach them with any concerns.

# Shepley House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 4 and 5 October 2016. The first day was unannounced. The inspection team consisted of one adult social care inspector.

Before our inspection we looked at information we held about the service including notifications in connection with accidents and incidents, deaths and deprivation of liberty safeguard authorisations. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider had been asked 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 the early scheduling of the inspection, the provider had not yet had the opportunity to complete the form; however, they completed it during the inspection and forwarded it to us for our information.

We contacted the local authority commissioners and safeguarding teams for the service, the local Healthwatch and the infection control lead for care homes. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection and inform our judgements.

During the inspection we spoke with 15 people living at the home, eight relatives, the registered manager, two senior care staff, seven care staff (including those from night shift) and the cook. We observed people's care to assist us in understanding the quality of care that people received. We spoke with one GP who was visiting the service during our inspection, and we used all of their comments to support the inspection.

During this inspection we carried out observations using 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.

We looked at six people's care and medicines records. We checked records in relation to the management of the service such as quality assurance checks and staff personnel files.

During the inspection we asked the provider to send us additional information. For example, a copy of their training information and copies of particular policies. They did this within the agreed timescales.

Requires Improvement

# Is the service safe?

## Our findings

We found a number of concerns when we checked safe management of medicines procedures. We observed medicines being signed for as administered at the service over both days of our inspection and on both floors, which included the upper floor dementia unit. We saw two different staff members dispense people's medicines into medicine 'pots' and leave them with the person to take unobserved, including on the dementia unit. When we checked people's records, we found that no one at the service self-administered their own medicines. This meant people were placed at risk of harm because staff had not followed safe administration procedures for people living in the service who required their medicines to be administered fully by staff.

We saw staff leaving medicines trolleys open and unattended while they administered medicines to people. This meant people were at risk of being able to access and possibly take a variety of medicines that were not prescribed to them. This was particularly concerning when it occurred on the dementia unit where people being supported may not have been able to recognise the risks associated with taking additional medicines, including those not prescribed to them.

A number of people that lived at the service had medicines prescribed to them which needed to be administered 30 to 60 minutes before food. We saw two people administered medicines that should have been given before food, after they had had breakfast. This meant not every person was receiving their medicines at the correct times as prescribed and also meant that medicines may not have been as effective as prescribed.

The medicine administration records (MAR) were not always filled in fully with details of why people had not had a particular medicine on certain days. All MAR's had codes which should have been used each time a medicine was not administered. This is important to ensure staff can be assured that everyone had either had their medicines or they had been accounted for.

We found that 'as required' medicines administered were not fully detailed with doses given or with the reasons why people were prescribed them. For example it was not recorded if one or two tablets were administered. 'As required' medicines are medicines used by people when the need arises; for example tablets for pain relief used for headaches. On one person's MAR we noted that guidance was not clear on one particular medicine and we were not able to confirm if their prescribed medicine was 'as required' as they had not been administered it for three days. The provider later confirmed that the MAR had not been completed fully, although the person had received their medicine as prescribed. This meant that there was potential for people to be placed at risk of harm associated with mismanagement of medicines, because records were not fully detailed and medicines administered had not always been recorded fully. After the inspection we received a copy of the person's MAR which confirmed that a new MAR was now in place to ensure staff administered the person's medicines correctly.

Some people were on respite care and were only to be at the service for a short period of time. We found some hand written MARs. The provider's medicines policy and good practice indicated that two staff

member should sign hand written MARs. However we found this had not always occurred.

Controlled drugs (CD) are prescribed medicines frequently used to treat, for example, severe pain. These are liable to abuse and for these reasons there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations. Part of the controls is that services have to make entries of any controlled drugs stored and administered in a separate register as well as on the MAR sheets. When we checked the register and counted a sample of remaining drugs, we found six ampules in total missing from one person who had since passed away at the service. Ampules are small sealed glass capsules containing a liquid (pain relief in this case), especially a measured quantity ready for injecting. We asked the registered manager about this and she told us that she would look into the matter. We were later shown evidence that the drugs had been accounted for by district nurses involved with providing additional care to the person. However, staff had not completed the entry into the register as required.

We found eye drops were not stored in refrigerated conditions as indicated on the medicines guidance, although the label was not clear; staff had not fully read the instruction and followed recommended storage procedures. This meant that these particular medicines may not have been as effective as they should have been because of inadequate storage.

Thick and easy which is a thickener, had been prescribed to one person, however, staff were using another person's thick and easy to administer their dose while their prescription was unused in the medicines cupboard. One relative confirmed that staff had used another person's prescribed thickener with their family member. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. We also found a tin of prescribed thickeners for one person stored in unlocked cupboards within the dining area of the dementia unit. This meant that staff were not using prescribed food for special medical purposes appropriately or storing them safely. This also presented a risk to people as thickening agents have the potential to cause asphyxiation if they are ingested. Following our inspection the provider informed us that a full audit of the services medicines procedures, staff competencies and training would be carried out. They also informed us that thickeners had been secured.

This is a breach of Regulation 12 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to the safe management of medicines.

During our inspection we noted a number of safety issues at the home. On the first day of the inspection a number of windows did not have restrictors in place or had devices which restricted the gap once opened. That meant the provider did not meet current Health and Safety Executive (HSE) guidance. A general risk assessment had been undertaken on the bedrooms on the ground and first floors in August 2015 and part of the action of the assessment was to consider window restrictors. The manager said she would immediately look to source appropriate restrictors and a few days later confirmed that window restrictors had been ordered and would be replaced within a few days.

On both days of the inspection, we saw that the rear exit door was open. This gave anyone access to the home from outside. On the second day of inspection we visited the laundry and found no staff members present but the door still open. This meant that anyone could have entered the building unseen and posed a risk to the welfare and safety of people living in the building. The registered manager said she would address this immediately to improve security.

During the inspection we found dishwasher tablets in unlocked cabinets within the dining area of the dementia unit. We also, on the same unit, found unattended chemicals which staff had used to clean parts

of the home. In communal bathrooms throughout the service, we found a variety of toiletries which people had used while bathing, but had been left on shelves when they had finished. This meant that staff had not ensured that dangerous chemicals were locked away for people's safety and that toiletries were also removed for the same reason and to prevent cross contamination.

Risk management plans were completed for every person who lived at the service. These were generic forms which covered various possible hazards associated with risk. For example, those associated with medicines, fire risk, use of stairs and bed rails. We noted that some people had a X marked against particular hazards which indicated that there was no risk, however, staff had completed information in the columns to indicate that there was some risk. These risk management plans did not show if the risk was high or low and did not offer staff information about the control measures in place to mitigate the risk. We spoke with the registered manager about this and they told us that they would look into this issue and that the paperwork was an area which was being looked at by the provider.

Maintenance and regular checks of the building and its equipment had been carried out, including for example, fire extinguishers, emergency lighting, lifts, gas and electrical checks and the addition of a new extension to the property. We noted that the five year electrical check had been completed, however was still classed as 'unsatisfactory' with comments on the certificate explaining that once the update to lighting was completed it would then be satisfactory. We asked the registered manager about this and they told us that they had been in touch with the provider. They responded by email and told us, "I believe the outstanding work (changing all the lighting to LED) is scheduled to take place before the end of the year. This work is being carried out throughout the company and we are part of that schedule." This meant that the electrical certificate was still showing as unsatisfactory.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 in relation to safe care and treatment.

Staff on duty at the service during the day, normally consisted of the registered manager and deputy manager, one senior care staff on each floor, with five or six care staff. There was also two domestic staff normally on duty and one laundry staff member. The kitchen staff were contracted out, but normally consisted of a cook and one assistant. In the office there was one administration officer. During the inspection we saw that there was three care staff on each floor with one senior member of care staff. We checked eight weeks' worth of staffing rotas and saw that there was either five or six care staff on duty each day with one senior.

On the dementia unit, in particular, it was extremely busy during the morning with one member of staff mostly dealing with people's breakfasts, while the other three care staff helped people get washed and ready. The building had long corridors with corners leading to further bedrooms and a variety of communal spaces, including lounges and dining areas. This made it particularly difficult to monitor what people were doing and allow staff to supervise them fully. Relatives we spoke with thought that there was not always enough staff. One relative told us, "It would be nice if they had more staff. Sometimes its hard to find anyone because they are seeing to someone in a bedroom or are too busy with someone else." Two care staff told us that at times they thought there could be more staff. We saw that people were not always being supported when they needed. For example, during breakfast, one person had finished their breakfast and wanted help but they were politely asked to sit and wait until the staff member was ready to support them. They then waited over 15 minutes for a staff member to assist them. We saw another person in the lounge that called for staff and waited over 10 minutes for staff to assist them, as staff were not in the vicinity and were helping another person at the other end of the building. Following our inspection, the manager told us that she was now completing a new form to enable an assessment of staffing levels, which would show that

they were staffing the home at recommended staffing levels.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 in relation to staffing.

People told us they felt safe living at the service and thought their personal possessions were safe too. Relatives told us they agreed with the thoughts of their family members on safety. One relative said, "I am very satisfied, could not be in a better place." Another relative told us, "Put it this way; I see no reason to think they [person] are not safe." The main door had a coded locking mechanism to ensure unwanted visitors could not gain entry and any visitors to the service were required to sign in and out. This meant that any additional visitors to the service could all be accounted for.

People were better protected from harm, because safeguarding procedures were in place and staff had been trained and understood their responsibilities when questioned.

Emergency procedures were in place and included a detailed contingency plan that staff would follow in the event of a serious incident occurring, for example, a flood, loss of utilities or severe weather conditions. The plan included checklists to support staff in ensuring they had dealt with all possible scenarios, for example, staff to liaise with emergency services, staff to divert incoming calls and place other staff on standby. There were also personal emergency evacuation plans (PEEPS) in place. These are details of each person's mobility and other relevant needs which would be handed to emergency services in order to support them evacuate people from the building safely in the event of a fire, for example. We were told by the registered manager that the local fire authority had recently been out to visit and were satisfied with the fire safety in the service. Although they could not confirm this in writing, we found nothing to suggest this was not the case.

Accidents were recorded and monitored by the provider, including sending details of low level issues to the local authority safeguarding teams. Staff had completed the correct forms to report any incidents or accidents to senior staff. We saw that senior staff completed a 'timeline' of events, including completing observation and body maps. Body maps are pictorial documents used in conjunction with written information to record the location, size and number of injuries which may has occurred during an accident. We saw that appropriate action had taken place to ensure that people had received the correct treatment or other remedial work was completed to address any issues that had occurred. For example, one person had suffered a minor injury. Staff had correctly reported and then taken the person to seek medical treatment. Fall logs were held on each person's records and these monitored the number of times each individual had fallen or not. There was also a separate falls risk assessment, which further supported the provider to monitor any patterns forming.

Staff recruitment records were held centrally by the provider organisation and the registered manager was provided with an email to confirm when all the necessary checks were in place. The registered manager did not keep a record of this so could not confirm for individual staff that all checks had been received. However, she was able to send us confirmation of all of these after the inspection.

We saw that the home was generally clean and tidy with cleaning schedules to confirm that work had taken place. The kitchen area had been awarded a food hygiene rating of five in February 2016 which was the highest possible to achieve from the Food Standards Agency. There was only one member of kitchen staff on duty at the time of the inspection due to sickness. We noticed that two care staff members had entered the kitchen without the correct protective equipment to minimise cross contamination. Other staff in the service were seen to be wearing protective equipment, for example, gloves and aprons, when they were about to

perform particular tasks. For example, personal care. Two relatives told us that carpets in particular places had malodours, but also said that the home was "Normally clean and tidy". We visited the area relatives had told us about and found that the carpet did have an odour. We brought these issues to the attention of the registered manager, who said she would act to address them as soon as possible.

Requires Improvement

# Is the service effective?

## Our findings

People told us that staff met their needs and assisted them whenever they needed help and support. They told us they felt staff were competent in the role they fulfilled. One person reflected, "Staff have helped me with anything I have asked for". Another person told us, "It is very relaxed here. The staff are very helpful and encouraging when it's needed. Where it is necessary they help with everything". Other comments included, "I am quite happy; I think they help me with everything" and "Every member of staff is pleasant, they have loads and loads of patience". One relative told us, "We think [person's name] is well looked after here. I think it is very comfortable and that all the residents are well looked after". A second relative said, "Nothing concerns me; [person] has improved since they came here".

Visiting healthcare professionals gave positive feedback about the service. One visiting GP commented, "The home is very good and they are proactive. They always have information ready for me when I come and people seem well looked after. If I need to refer anyone, they are supportive."

Staff received induction training that was in line with the Care Certificate and we saw evidence of training records and staff files. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards.

Staff had received a range of training, including what the provider considered as mandatory and specific training, including dementia awareness, infection control, moving and handling and equality and diversity. All staff at the service had their training monitored and monitoring showed that 100% of staff had completed the required training. We noted that many of the staff at the service had qualifications in health and social care at diploma levels two and three. Staff told us they were encouraged to keep up to date with their training and supported to take additional training that was relevant to their role, for example, basic life support for care staff, display screen equipment training for the administrator and COSHH training for domestic staff. COSHH stands for 'control substances that are hazardous to health'. This meant that the provider ensured that staff were trained and had the knowledge and up to date skills to carry out their roles and responsibilities.

The organisation had recognised the need to provide staff with further dementia training and awareness and had developed a strategy called "Enter My World" to support people living with dementia. This was being rolled out across services where people with dementia related conditions lived.

Staff told us they felt supported by their line manager and the provider as a whole. We saw that supervision and regular team meetings took place. Staff had the opportunity to discuss a range of topics, including for example, training and best practice in dress code. The provider had recently introduced a system for yearly appraisal for all staff, and the registered manager informed us that training was in place for all senior staff to ensure a consistent approach to supervision and appraisal. We noted, however that this was the first time appraisals had been completed. There was no evidence of staff who had worked for the provider for a number of years having had support through an appraisal system.

We sat in on a well communicated morning shift handover and observed how staff passed information from one staff shift to another. This meant staff coming on duty were fully updated with any pertinent issues before they started work and were aware of any concerns that they may have needed to address. A GP who was visiting the service told us "It's one of the better homes for communication" and "You get the same treatment whether you come announced or unannounced and staff are very helpful."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Livery Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found they were. One application had been granted to deprive the person of their liberty and other applications were still being processed. Staff had received training in the MCA and DoLS and understood their responsibilities with regard to complying with the MCA. However, three staff were not easily able to say how many people were under the protection of a DoLS authorisation. As 50% of care staff on a particular unit were uncertain about DoLS, this meant there was a risk that people may not have been protected fully under the legal framework of the MCA because staff were not always clear on who had an authorisation in place.

Care files contained consent forms for a variety of events, including taking pictures and agreeing to the care and treatment provided. Consent had been signed by either the person who lived at the service or by their legal representative. On the dementia unit we saw that particular decisions had been made for people, who we were told, could not always make their own decisions. However, we did not always see who had been involved in the best interest decision making process. Three relatives confirmed that any decisions were discussed with them and they also confirmed that other healthcare professionals were involved in the process. We were satisfied that any best interest decisions were made with other relevant people involved, but that records were not always kept. We spoke with the registered manager, who confirmed that they had not always recorded best interest decisions and needed to do so in the future. She told us that the decision making form was currently being updated. She said she would discuss the issue regarding DoLS authorisations with staff.

We recommend that the provider ensures that staff are fully aware of which people are protected under a DoLS authorisation and that best interest decisions are fully recorded.

Information was obtained from people and their relatives during initial assessment and entry to the home, in connection to any lasting power of attorney that may have been appointed and copies were held in the office to ensure that the service had full details. Any advanced decisions or people's wishes for their passing, were gathered and recorded as appropriate by staff at the service. This meant that the provider had gathered consent and information about how people wished to be treated when they may have no longer been able to make those types of decisions.

Staff had been encouraged to have a flu vaccination and from records we saw that over two thirds had taken up this injection. People also had the opportunity to have the flu vaccination as the visiting GP told us. This meant that the provider had taken proactive measures to keep people from transmitting the flu virus.

People told us they enjoyed the food which was prepared for them. One person told us, "Don't tell [cooks

name] but their lasagne and garlic bread is better than most places I have eaten; really good." Another person said, "[Cooks name] does a good job. I love the puddings, they are my favourite." People received a range of food and refreshments in a timely manner. Staff understood how to provide additional support for people when they needed it. For example, kitchen staff explained that they provided people with additional supplements when they were at risk of malnutrition, in the form of milk shakes or food with cream added to boost their calories intake.

One staff member helped a person who was on a softened diet, to eat their meal. The weights of people were recorded and people had their weight monitored with both loss and gains being recorded. People's likes & dislikes were detailed and kitchen staff had full details and knowledge of people's preferences, including any allergies and special diets they required when we spoke to them. For example, they were able to tell us that one person was allergic to bananas. The cook was able to describe how they monitored which food went to particular individuals to ensure they received meals appropriate to their needs. This meant that people who required additional nutrition had this written in their care records and staff followed this guidance. When concerns were identified about a person's weight, this was monitored by senior staff at the service.

Relatives confirmed that their family members received cooked breakfasts if they so wished. One relative told us, "[Person's name] likes cereal and toast. They love it, but not always. If they want something different, it never seems a problem." We saw menus with a variety of choices for people to have. When we visited the kitchen, the fresh, dried and frozen food types we found in store cupboards, fridges and freezers aligned themselves with menus. We observed breakfast, lunch and tea time experiences over the inspection period. People were seen eating their meals in a contented manner with support from staff if needed. One person made noises of satisfaction with, "mmmm and mmmm" throughout their mealtime experience. When we asked one member of care staff about this, they said, "[Person's name] really enjoys their food and makes that noise." We noticed a sign on display in the main foyer of the home. It stated there was going to be an "Apple pudding day" on the 23 October 2016 and people were asked to vote for their favourite apple pudding. This meant that staff had thought of different activities to encourage people to share their food preferences.

People received input into their care from external healthcare professionals such as opticians, chiropodists and GP's. In addition, where people needed more specialist input into their care, from, for example speech and language therapists and challenging behaviour teams, this input was sought by the service. In the recent months prior to our inspection an incident occurred in which medical attention was sought for one person in a timely manner. We spoke with a GP during the inspection, who told us that the staff at the service were proactive in requesting support and liaising with healthcare professionals if they recognised a need. This meant people were supported to maintain good health and had access to healthcare services should the need arise.

We found adaptions had been made in certain parts of the building. For example drawers and cupboards with view slots, to allow people living with dementia to see what is in each draw without having to open them to look. This type of equipment supports people living with dementia to live more independently. Signage was in place which supported people to orientate themselves around the building better, particularly on the dementia unit. Notice boards with date, time and weather details to further support people were also in place. The registered manager told us that they had visited Stirling University with other managers from the organisation with the aim of seeking good practice in the caring of people living with dementia. She told us that they were using their design ideas in the refurbishment of the building that was due to be started as part of the organisation and local authority's building programme.

The service had a large garden designed to accommodate people with reduced mobility and those who used wheelchairs. There was a garden room, raised beds in places, a small pond and fountain and the area was fully secure with fencing to all sides. This meant that the provider had effectively developed a safe environment for all of the people living at the home to use, including those living with dementia.

Good

# Is the service caring?

## Our findings

People and relatives we spoke with were complimentary about the caring attributes of the staff team. We saw two care staff waving to people who were looking out of their windows at the time, as they came to work for the morning shift. Comments from people who lived at the service included, "Staff do anything for you and they are very kind"; "There are some lovely people working in here. Very kind" and "I wouldn't live here if they [staff] didn't care – it would be horrible." Comments from relatives included, "The staff team are brilliant"; "They are always clean and happy. The staff are lovely. They treat [person] well, they are very kind. There is all sorts going on. We have never found any faults or needed to complain. Everything is very good"; "I ask every day if things are okay. [Person] always says yes"; "[care staff name] thinks the world of [relative]" and "Carers are nice, really nice staff." A visiting GP told us, "I have never had any cause for concern about the care provided here. Staff always seem very caring in their nature."

One relative gave us an example of the kindness shown to their family member. They told us that the person had a quilt on their bed but found it rather heavy. The relative told us, "Staff went out of their way to find a lighter one to make [person's name] happy and comfortable. They were very good."

We asked care staff about the care they provided. One said, "I'm most proud of how people look at us and recognise us. We're not strangers to them, they trust us and love living here. It is their home and we do everything we can to make sure this is always the case." Another staff member told us they got to know people by chatting with them whenever they could, such as during mobility support and during meals.

People told us that the staff made sure they were comfortable and not hungry. During our observations we saw a care assistant had brought one person a meal for lunch. The person said, "I don't want it." The staff member said, "Let's try it, I don't want you to go hungry. I'll leave it to see if you fancy it. If you don't I'll get you something different." The person still refused and did not want anything different. The staff member then said (in a caring and friendly manner), "Do you want some pudding?" This resulted in the person eating dessert rather than nothing.

We saw staff demonstrated kindness and familiarity to people, such as holding the hand of an anxious person until they were settled in a seat they liked during lunch time. We saw staff were able to successfully comfort a person who had become agitated and seemed to understand each person's personality which made it easier for them to support people with their individual needs.

People knew the names of staff within the service, including kitchen and activity staff. We saw staff had built positive, caring and compassionate relationships with people based on their likes and interests. For example, a member of care staff told us that one person liked to help in the dining area, with clearing dishes. They told us that when they [person] wanted to do this, they tried to encourage them in a safe way to be able to complete the task.

There was evidence in place to demonstrate that people and their relatives had been actively involved in the development of care plans. When we spoke with people and their families, they confirmed that they felt they

had been fully involved. One person said, "They [staff] asked loads of questions when I moved in. I think my son helped with some things I had forgotten."

Information on a range of subjects was available in the reception area and throughout the service to help people. There was guidance on safeguarding, advocacy information, a service guide, dementia support and contact numbers for a range of support agencies and health care professionals. Staff told us that no one at the service was currently receiving support from an advocacy service, and one said, "If someone needed help, we would just make sure they got it. Like anything else they needed." An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

People we spoke with told us that the staff promoted their independence. One person told us they went out regularly with members of their family. Another person told us, "Staff encourage me to do things that they know I can. Better that, than ending up having everything done for you."

People we spoke with said that the staff treated them with dignity and respect. One person said, "They [staff] always knock. It's good that." A relative told us, "They look after [person's name] well; always clean and tidy. They used to be a stickler for that, so I am sure it pleases them to be looked after the same here." Staff we spoke with were mindful of people's rights to have their privacy and dignity respected and we also saw that ways to promote people's privacy and dignity was documented in care plans for people.

People's belongings were not always treated with respect. We spoke with a number of people and relatives throughout our inspection and many had comments to make about clothing returned to them from the laundry. They told us that clothes were sometimes not returned in good order, that clothes were returned to the wrong person and that sometimes clothes took a long time to be returned after they had been sent for laundering. Two relatives told us that their family members had, on a number of occasions, ran out of night dresses and underwear when they had many garments in their possession. Another relative told us, "I am forever finding other people's labelled clothes in their wardrobe."

During our inspection we found eight pairs, of what we assumed were reading glasses, in a drawer within a dining room cabinet on the dementia unit. When we asked two relatives if their family member had ever lost any glasses at any point, one of them told us they had and said they had never been found. We found no evidence to suggest that people were left without reading aids, however this meant that people's personal belongings were not respected and looked after as well as they should have been. This included returning lost belongings to people. We spoke with the registered manager about the clothing issues and they said they would look into the matter with staff.

We recommend that the provider ensures that people's belongings are respected and returned to them in a timely manner and puts in place best practice procedures to ensure this occurs.

Requires Improvement

# Is the service responsive?

## Our findings

Each person had very 'person centred' individualised records which were used to help staff care plan the person's daily needs such as mobility, personal hygiene, nutrition and health needs and these were reviewed monthly. Records included, one page profiles, lists of individuals who support the person (family and staff) and a map of life. The map of life was particularly detailed and gave information about where the person was born, where they had lived, who they had married, their children, interests, employment, pets, childhood memories and friends.

People's records also gave staff specific information about how the people's needs were to be met and gave staff instructions about the frequency of interventions. However, we found that it was not always easy to negotiate our way through the wealth of information to establish the precise needs of individuals and found some care plans not in place, for example with regard to medicines. As detailed in the safe domain, we found several concerns in relation to medicines which demonstrated staff did not have the correct document guidance to ensure the effective administration of medicine. Staff we spoke with knew people very well without making reference to records. We were confident that people's needs, outside of medicines concerns, were being addressed by staff who had worked at the service for many years, although there was potential for needs to be unmet when newer staff were on duty. We spoke with both the registered manager and the head of care about this issue and they agreed that paperwork needed to be reviewed and confirmed that this, in fact was in the process of being reviewed.

Relatives confirmed that staff were responsive to people's needs. One relative gave us an example and said that they sometimes cleaned their family member's nails for them when they visited and continued, "But I know someone has done them in between." One person told us, "Nothing is any trouble to them [staff]. If I ask for something, they will do their best to get it. Cannot grumble at that can you?"

The service had a new dedicated activities co-ordinator who had worked at the service for a number of weeks. This meant that people had more opportunities to participate in activities. People and relatives told us that there was a range of activities for them to participate in if they wanted to, including exercise, going out, various crafts, pampering sessions and a variety of games. We saw a list of activities on display which confirmed this. A selection of library books were available to those who enjoyed reading. One relative told us, "[Name of activity coordinator] sits with [person's name] every day and goes through picture cards with them, which is very good." Another relative told us that the activity coordinator had made a "change for the better" since they had started to work at the service. One person told us that the activity coordinator had sat and chatted with them while painting their nails. Another person told us that there was a large TV screen in the downstairs lounge and from time to time staff put old films on for people to watch. We also observed staff putting on nostalgic music tapes for people to listen to, including songs from the war years. We overheard some people singing along at various points during the inspection.

The service had a summer house in the garden area and we visited this during our inspection. We were told it had been used in warmer weather to hold tea parties and other events and we saw pictures to confirm this. Care staff told us the summer house was also used by the activity coordinator to do craft activities with

people. We saw that toiletries were displayed and for sale at particular times and the registered manager told us they had held a 'sweet' tasting session in the same area for people to try confectionery items from years gone by in order to jog memories; telling us they had also set the space up as an olden day sweet shop.

One relative told us that at Christmas the staff normally organised carol singers to come to the home and sing for the people living there. They said, "We usually get people from the church come along and sometimes children from one of the local schools can come too. It's lovely for them (people)." Staff confirmed this to be the case.

There was a hairdressing room available. People used this room on a weekly basis to visit the hairdresser. People told us that they enjoyed having their hair washed and tidied and one person said, "It makes you feel better when you have had your hair done." They then asked a member of care staff, "It looks lovely doesn't it?" This was asked just after they had come out of the hairdresser's room. Throughout one day of the inspection, many people were seen to have had their hair cut and tidied and the experience was like that of what you would expect in a high street. People were seen with dryers on and rollers in place while sitting reading magazines and looking very content.

Various events were organised by staff at the service to encourage people to make friends and avoid social isolation, including a forthcoming apple pudding day, going out for meals and various activities which took place in the services separate 'day care' service. People were able to participate in activities which occurred in the day care service if there was space permitting, which we were told, there often was. This meant that people had the advantage of meeting different people and sharing their experiences while participating in other stimulating activities.

We spoke with the registered manager about IT programmes and other ideas that they could be used with people living with dementia, including giving them details of an app designed by Liverpool Museum to support the work of the activity coordinator. The registered manager told us that they linked in with the likes of Stirling University's website to seek good practice and noted our comments to pass on to staff.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. One person told us that a member of the church had been in to see them the day before the inspection and they told us that this was a regular event. One staff member told us, "If anyone wants to go to church, we will support them in any way we can."

People had choice. One relative confirmed that their family member sometimes preferred not to join in activities and chose instead, to stay in their room. Another relative confirmed that their family member would stay in their room if they wanted to and at other times enjoyed sitting in the lounge watching out of the window or watching TV. We saw that at meal times people had a choice in the type of food they had to eat and suitable alternatives were offered if they did not like particular food.

There was a complaints procedure in place that was made available to people and their relatives. Records showed that there had been seven complaints since the start of the year and all complaints or concerns raised were dealt with immediately by the registered manager. This supported what people and their relatives had told us. One relative said, "We have not had any reason to complain, but if we did I know that it

would be taken seriously". Another relative told us, "I have had absolutely no reason to complain, none at all." There had also been many compliments received at the service for the caring attitude of staff and "wonderful jobs" done with relatives who lived at the service. We saw examples of these on notice boards, in records kept within the office and on the internet via a separate website dedicated to gather the views from people and their relatives in care homes across the UK.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager in post at the service. They had worked for the provider since 1992 and had become the manager in 1999. They were currently supporting another service within the organisation and spent approximately half their time at Shepley House and the other half at the other service. They told us they had been covering both services since August 2016 and that this was soon to end as a new manager had been appointed at the other service.

Senior carers would review support plans regularly and the deputy and registered manager audited these to ensure that appropriate actions had been taken. They also completed regular 'walks around' the building to ensure that standards were maintained.

However, we saw on both floors of the service, that people's personal care and support records were not always secured in locked cabinets. On the first day of the inspection, we found people's records on full open display in communal areas in which visitors and people who lived at the service had full access to. We also found that archived records were not filed away appropriately and had been placed inside cupboards in mixed piles from various people, including falls assessments, lists of people requiring a visit by a GP, discharge from hospital forms and people's daily records. On the second day of the inspection, paperwork had been placed in cupboards but doors were not locked and therefore still accessible by anyone. We spoke with the registered manager about this who was already aware that this was an issue.

We saw in staff records that two staff involved with administering medicines had discussions with management at the service about previous medicines issues, including one person not receiving their medicines. This meant that the registered manager was aware of some concerns with medicines procedures, but had not fully addressed these concerns as some of the same issues were found during the inspection.

There were a range of audits and checks in place, some of which were completed by the deputy manager and registered manager and others by the provider's quality assurance team and separate health and safety professionals. However the systems in place to review and audit the quality of care had not identified the issues we saw during our inspection, such as ensuring the safe management of medicines and that care plans reflect identified need and risk.

Medicines audits were generally completed by the deputy manager. The registered manager said she checked these, although no signature to confirm this was seen on documentation. When we looked at the audit document it was written in a way which meant staff would miss finding some of the issues that we found during our inspection. The form was not clear in what the checks were requiring staff to do. For example, in the section marked "Spot checks", we saw that one entry entitled "missed signatures on MAR sheets" was ringed as "ok", when in fact there were missed signatures. We also noted that any actions that were noted did not have details of whom was to take the action and when it had been completed.

Care plan audits were completed to ensure that people's records were accurate and up to date. When we

looked at the record of these checks and asked the registered manager how these were completed, she told us that they were completed, "Sometimes by triggers or falls or if someone has deteriorated" There was no summary of which records had been completed, so we found it difficult to monitor which had been done or not. The registered manager said that she was going to put the audit documentation in people's rooms in date order and if a section was blank that meant it needed to be checked.

The registered manager had completed night audits, including a recent one on the 14 August 2016. This audit had checked security of the building, how long call bells had taken to be answered and any care recordings made. The audit had noted two longer than average call bell responses, but did not record what action had been taken and by whom to look into this matter or the outcome.

A general risk assessment had been undertaken with regard to people's bedrooms in August 2015 by a health and safety representative of the provider. In the assessment, a recommendation had been made to consider a particular action in connection with window restrictors. We saw no evidence that any consideration had been taken and no actions had been put in place to comply with HSE guidance. This meant that people were placed at unneeded risk due to the recommendation not being followed up.

In 2015 an alert had been sent to all care home providers in England about an incident involving the death of one person involving the incorrect use of thickeners. We saw that information about the alert was available within the service for staff to see, yet systems were ineffective to implement recommendations. Staff were aware that thickeners were held in unlocked cupboards, as two staff members told us where they were kept; yet the registered manager had failed to see this through quality assurance checks completed within the service.

The registered manager told us that appraisals were in the process of taking place, with the role out of a new system and staff, including herself, had attended appraisal training. We asked when previous appraisals had occurred and she told us that this was the first time. This meant that staff may not have been given full opportunities to develop themselves because the provider had not used appraisal systems previously.

It is a legal responsibility of the registered person to send the Commission notifications of certain accidents or incidents and also if a person is authorised or declined a DoLS application. The registered manager had failed to send us one notification for a DoLS authorisation which was confirmed in 2014. Although we had noted that all other notifications had been sent to us in a timely manner.

These are breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 and in relation to good governance.

People and their relatives spoke well of the management team, including the registered manager and the deputy manager. One person said, "I see both of them around here from time to time. They usually ask how I am and check everything is ok, which is nice." One relative told us, "I have nothing but gratitude to them both [registered and deputy manager]. They have helped me enormously and for that I can only be thankful." Another person told us, "Yes, nice people. We see more of the staff though, but of course they are the ones who do everything for us." Another relative told us, "You can go to speak to anyone in the office. They always listen and have time to help."

Staff told us they enjoyed working at the service. Many staff had worked there for a number of years. One member of care staff told us, "It's nice to have some continuity with staff who have been here a while. It's important that people see a friendly face they know." One staff member told us, "The deputy is very good and will help with anything she can, she is my line manager. We have meetings and talk about everything to

do with the home."

Employees had the opportunity to be nominated for an employee award by people and their relatives. We saw nomination forms in the reception area of the home. The awards were split into six categories, including 'best newcomer' and carer of the year'. One relative told us, "Its really good to get an opportunity to thank staff in this way. I will be completing one of those." This meant that the provider actively celebrated the positive work of its staff and encouraged people and their relatives to play a part of the celebration.

Regular staff meetings took place to ensure that staff had an opportunity to discuss any issues arising, including changes to the organisation and personal issues relevant to staff, for example, holidays. We saw that recent staff meetings had discussed the proposed refurbishment plans involved with the proposals from the local authority to complete a full refurbishment or rebuild of the premises in line with their 'Vision 2020'. However, one staff member told us that the provider could have discussed the proposed changes sooner as they heard about them from outside of the organisation first.

Surveys were distributed to people and their families regularly by the provider and these gathered the views of what people and their relatives thought of the care and support provided. We saw a suggestion box in the reception area with cards available for people to fill in at any time which asked particular questions, for example, if the person or relative wanted to "point out a problem or make a suggestion". The form also gave people and relatives the opportunity to score particular elements of the service between a rating of 1-5, including form example, "staff attitude and approach, comfort of rooms and quality of food". We noted the wording on the suggestion card did not lend itself well to a positive response as it stated, "If you would like us to follow up the comments you share with us, please provide the following details: (name, telephone number etc.)". We showed the card to one relative to gain their opinion who said, "It reads as though, if you did not fill your name in, that no one would take any notice of what you had to say." We shared their views.

The service had a good working relationship with the local GP surgery attached to the service with a weekly visit from the practice taking place. We spoke with a GP on their weekly visit and they told us that the visits were working well. They said, "I am sure it has certainly benefited the people living here. Staff are responsive and will let us know before we visit if there are any issues we need to be aware of." Staff and the GP met to discuss concerns before a 'round' of people to be visited was undertaken. Staff told us, "It's much better that the doctor comes every week now, as we can nip things in the bud before they get serious, which can only be good." This meant by having a good partnership with healthcare professionals, people were kept as healthy as possible.

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 18 HSCA RA Regulations 2014 Staffing<br><br>There were not enough staff present to meet the needs of people living at the service.<br><br>Regulation 18 (1) |