Essential Healthcare Solutions Limited

The Shrubbery Rest Home

Inspection report

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Wolverhampton
West Midlands
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Tel: 01902844871

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 31 January 2017. This was an unannounced inspection. Our last inspection took place in November 2015 and we found when people lacked capacity to make decisions for themselves capacity assessment and best interest decisions had not been completed. At this inspection we found the provider had made some improvements however further improvements were needed.

The service was registered to provide accommodation for up to 26 people. At the time of our inspection, 23 people were using the service.

There was not a registered manager in post. A new manager had very recently been appointed who had commenced the CQC registered managers application process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from potential abuse as concerns were not investigated or reported appropriately. Risks to people were not always managed in a safe way. When incidents occurred sometimes no action was taken to ensure these were reviewed and avoid any reoccurrence. When people had behaviours that may challenge staff offered an inconsistent approach. Staff did not always have information about moving and handling to ensure people were supported in a safe way. When needed mental capacity assessments had been completed however decision had not always been made in people's best interests.

The provider was not always notifying us about significant events that had occurred in the home. The quality audits that had been introduced had not all been completed and therefore we could not be sure they were effective.

People were supported in a caring way by staff they liked. Staff had received an induction and training to help them offer support to people. There were enough staff available to offer support. People were encouraged to make choices about their day and remain independent.

People enjoyed the food and were offered a choice. They had the opportunity to participate in activities they enjoyed. Medicines were managed in a safe way to ensure people were protected from the risks associated to them. When needed people had access to health professionals.

Staff felt listened to and supported by the new manager. People knew how to complain and complaints had been responded to in line with the provider's procedures. Staff knew people well and they felt involved with planning their care.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
People were not always protected from potential harm as concerns were not always investigated or appropriately reported to the local authority. Risks to people were not always managed in a safe way. There were enough staff available for people and they did not have to wait for support. Medicines were administered recorded and stored to ensure people were protected from the risks associated to them.

Is the service effective?

Requires Improvement

The service was not consistently effective.
When needed mental capacity had been assessed however decisions were not always made in people's best interests. The provider had considered when people were being unlawfully restricted and had made applications to the local authority; however staff did not fully understand this. People enjoyed the food and were offered a choice. Staff received an induction and training that helped then offer support to people. People had access to health professionals when needed.

Is the service caring?

Good

The service was caring.
People were supported in a caring way by staff they were happy with. People were encouraged to be independent and make choices about how to spend their day. People's privacy and dignity was maintained. Friends and relatives were free to visit when they chose.

Is the service responsive?

Good

The service was responsive.
People had the opportunity to take part in activities they enjoyed. Staff knew people well. People and relatives felt involved with reviewing their care. People knew how to complain and when needed the provider had responded to complaints in line with their procedures.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider was not always notifying us of significant events that occurred at the home. Systems that were in place to review and monitor care were not always effective. There were some systems in place to monitor the quality of the service, however further improvements were needed. Staff were happy with the new manager and felt they were listened to. The provider sought the opinions from people who used the service. Staff were aware of the whistle blowing procedure.

The Shrubbery Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 visit took place on the 31 January 2017 and was unannounced. The inspection visit was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We used this to formulate our inspection plan.

On this occasion we did not ask the provider to send us 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. However we offered the provider the opportunity to share information they felt relevant with us during the inspection visit.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with ten people who used the service, three relatives, three members of care staff, the manager and one of the providers. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for four people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

We saw there were procedures in place to report concerns of potential abuse to the local authority; however these procedures were not always followed. For example, we looked at the incident and accident forms for the home. Records showed that three altercations had taken place between different people. We saw that these had been documented but no action had been taken to investigate how these had occurred and how to reduce risks in the future. Other records we looked at, including behaviour charts and health records showed further incidents had occurred that had resulted in injury. Records showed that staff did not know the cause of the incidents and they had not reported either incident as required to the local authority for investigation. The manager and provider confirmed these had not been reported to the local authority and we had not received a notification about these incidents. This meant we could not be sure people were protected from potential abuse.

This is a breach of Regulation 13 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Risks to people were not always managed in a safe way. For example, we looked at records and saw for one person they had fallen twice in a twenty five day period. The records showed that the fall had occurred in the same place and no action had been taken to reduce the risk of this happening again. In-between the falls occurring a routine review of the care plan had taken place and there was no reference to the incident occurring. The records stated 'no concerns'. No review had taken place since the second fall. We spoke with the manager and the provider who told us after incidents had occurred reviews did not always take place. This meant the person was at risk of further falls as there were no systems in place to manage these falls or to look at how to keep the person safe.

We saw that one person was transferred from their wheelchair to the sofa. Two staff did this by holding the person under the arms, holding their clothes and pulling them up to a standing position. We asked to see the records for this person. As the person was receiving a short stay at the home we were told that no records had been completed and there was no guidance in place for staff to follow. We spoke with staff about this. One staff member told us, "I don't really know how to transfer them; I am just following what the other staff are doing". The manager told us they had completed a pre admission assessment prior to the person coming into the home. We looked at this. This stated the person 'has great upper strength and the ability to lift themselves up'. After the transfer we spoke with the person they said, "I'm not sure why we did it like that". They confirmed that they could transfer their selves between chairs. Later in the day we saw the person do this independently. This meant the provider had not ensured staff had the information available to transfer this person in a safe way.

When people had behaviours that challenged the guidance in place for staff was limited and we saw staff offered an inconsistent approach. For example, the records for one person identified them as being 'verbally and physically aggressive'. It stated this aggression could be directed at other people putting them at potential risk. There was a risk assessment and a behaviour management in plan for these behaviours; however this documentation provided mixed guidance. It said, 'there are no triggers for these behaviours'

however further on its stated 'staff to be aware of trigger points'. It was also documented when the behaviours occurred staff should 'avert attention to something else' there was no further information as to what this maybe. We spoke with staff who were able to tell us the trigger points for this person were. However staff offered a different view of how they supported the person. One staff member said, "I would give them their own space and leave them alone, sometimes that makes them worse". Another staff member told us, "I would talk to [person] calmly and find out what the problem was, maybe offer to go to their room with them or have a cup of tea, they like a cup of tea". The third staff member told us they were unsure how to manage this situation. Records we looked at showed incidents of verbal and physical aggression had continued and no action had been taken to address these behaviours.

This is a breach of Regulation 12 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

There were enough staff available and we saw people did not have to wait for support. One person said, "Good staff. There is usually enough staff on duty so I don't have a long wait when I press my buzzer even at night". A relative told us, "Yes I think there is enough staff". We saw that when people needed support staff responded in a timely manner. For example, when people requested assistance staff were available within communal areas for people. We spoke with the manager who showed us a dependency tool that they had recently introduced to ensure there were enough staff available within the home. The tool was based on people's dependency needs.

We spoke with staff about the recruitment process. One member of staff who had recently started working within the home said, "I had to wait for my DBS and references to come through before I could start". The Disclosure and Barring Service (DBS) is the national agency that keeps records of criminal convictions. We looked at three recruitment files and saw pre-employment checks were completed before staff could start working within the home. This demonstrated the provider ensured the staff working in the home were suitable to do so.

Medicines were administered to people in a safe way and staff spent time with people ensuring they had taken them. One person said, "I get my medication at the right time which is important". We saw people were offered medicines for pain relief. This is known as, 'as required medicines'. When people received as required medicines we saw there was guidance in place for staff, stating when they could receive this medicines and how much they could have. We saw staff explain what the medicines were and gained consent from the person before administering them. Medicines were appropriately recorded when they arrived at the home and stored to ensure people were protected from the risks associated to them.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 6 May 2015, we found people's rights under the Mental Capacity Act 2005 (MCA) were not being met. At this inspection we found the necessary improvements had been made to comply with the regulation.

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

We checked to see if the provider was working within the principles of the MCA. We saw when people lacked capacity to make certain decisions for themselves mental capacity assessments had been completed. We saw this was for key areas such as finances and decisions to see a medical professional however; it was not specific to the decision that was being made. We also saw that some best interest decisions had been completed for example, decisions around do not resuscitate had been agreed in a person's best interest. However, for other decisions including the use of bed rails and living at the home we did not always see these had been agreed in the person's best interest. We spoke with the manager and provider who had identified this as an area requiring improvement. Staff we spoke with demonstrated an understanding of the Act. They told us they had received training since our last inspection. One staff member said, "We looked at this after the last inspection". Another staff member said, "I know we have to always assume capacity". Another staff member told us about the importance of gaining consent from people. They said, "We asked people if they are in agreement when we are carrying out care with the person. They have also agreed through the paperwork that is in place". We saw staff gain consent from people. For example, people were asked if they wanted help and support or assistance to move around the home. This demonstrated that staff understood the importance of gaining consent from people.

The provider had considered when people were being restricted unlawfully and applications when needed had been made to the local authority, however we did not see any evidence that risk assessments were completed to ensure people were being supported in the least restrictive way while approvals were being considered. Staff we spoke with demonstrated some understanding of DoLS and how they would support the people with this. A staff member said, "I know what DoLS is. It is when we are restricting someone to keep them safe, as they can't make that decision for themselves". However staff could not tell us if any approvals were in place. The manager and provider told us this was an area that they were working to improve and were currently in the process of reviewing people's mental capacity and DoLS applications.

Staff received training and an induction that helped then to support people. One staff member was currently undergoing their induction. They said, "I am on a shadow shift today. I am shadowing other staff until I feel comfortable, I think it's great as I haven't worked in care before". They also told us they had received training

and had the opportunity to look at policy and procedures as part of their induction. Other staff told us about recent training they had undertaken. One staff member said, "We have just completed all our mandatory training this month. It was a refresher so it keeps you up to date". Another staff member told us about the recent training they had completed. They said, "It was good, I had moving and handling training". This meant staff received an induction and training that helped them to support people.

People enjoyed the food and there was a choice available. One person said, "The Food is excellent. We usually have juice on the tables". Another person told us, "I'm vegetarian and they do a good job with my food. There is a drink trolley mid-morning and mid-afternoon". We saw that people were offered a choice at breakfast and lunchtime. When needed staff spent time with people and offered them support. When people needed specialist diets we saw this was provided for them in line with these recommendations. Records we looked at included an assessment of people's nutritionals risks. We saw when these risks had been identified people had their food and fluid intake monitored, so concerns could be identified. Throughout the day people were offered a choice of hot and cold drinks and snacks were also available.

People told us they accessed healthcare when needed. One person said, "I have the person do my nails and the doctor comes in to see me if I am unwell". Another person told us, "Very good doctors that come to the house, when I hurt my finger the other week they came quickly and advised the staff to call for an ambulance". We saw when needed people had been referred to health professionals. For example, physiotherapists and speech and language therapist when concerns had been identified.

Good

Is the service caring?

Our findings

People and relatives told us they were happy with the staff. One person said, "The staff are nice. They are good to us, anything you want you just have to ask". Another said, "I get good care here, I can't complain". We saw staff stopping to talk to people. The atmosphere appeared relaxed and friendly. A relative told us, "I think this is very homely and I would recommend it to other people". We saw staff supported people in a caring way. For example, when people had fallen asleep in their armchairs we saw staff wrap blankets around people to keep them warm. They also position people with cushions to ensure they were in a comfortable position.

People told us they made choices about their day. One person said, "I pop in and out of my bedroom all day. That way I have the company when I want and the quiet when I chose". Another person told us, "I prefer watching the activities rather than joining in, it's not for me. They always ask me but they don't force me". We saw staff offering people choice about what they would like to do and where they would like to sit.

People's privacy and dignity was promoted. One person said, "They always knock on my door and are respectful when other people are around". We observed when staff offered support to people in communal areas a screen was used to maintain people's privacy. One person told us, "They put that round you if the doctor comes so the others can't see. Its good, it saves me getting up and going to my room". Staff gave examples how they maintained people's privacy and dignity. On staff member said, "I would explain what I was going to do. Be considerate, make sure no one else could see and the doors and curtains were closed".

People's independence was promoted. One person said, "I like to get on with it myself". Staff gave us examples how they encouraged people to be independent. One staff member said, "I ask them if they can or want to do it for themselves first. If they want me to support them I will".

Relatives and friends could visit anytime. One person said, "My family can come when they chose". A relative told us, "There are no set times so we can drop in whenever we choose, day or night". Another relative told us, "[Person using the service] gets on well with all the staff, who always take time to talk to us". We saw friends and relatives visited throughout the day.

Good

Is the service responsive?

Our findings

People were able to take part in activities they enjoyed. One person spoke about the activities and entertainment. They said, "We have some activities like bingo". There was not currently an activity coordinator in post; the provider told us they were in the process of recruiting to this role. The manager told us that staff were ensuring activities took place in the interim. We saw there was an activity taking place. This was exercises and bowling. People were laughing and joining in shouting out during the activity. One person commented, "Have a go, its great". We saw pictures were displayed about previous events that had taken place. One person commented, "Look that was during the summer".

People and relatives told us they were involved with reviewing their care. We saw when needed people had consented to their relative's involvement. One person said, "They ask me before about my care". A relative told us, "I am quite happy to leave care plans to the staff." The care files we looked at showed people and their relatives, where appropriate, were involved with reviews of their care and support.

Staff knew about people's needs and preferences. One person told us, "They know me yes". Another person said, "I like to read the paper so they remind me as sometimes I forget". Staff told us they were able to read people's care plans to find out information. One member of staff said, "We have the opportunity to read people's files. Although working with the person is better as you get to know them, all the information is still written down for us". There were daily arrangements in place to keep staff informed about people's needs. One member of staff said, "We have the new sheets and they are a quick over review of the people which are really useful, if something has happened we change them so everyone knows". This demonstrated that staff were updated about the changing needs of people. We saw people had information in their files about their life history, likes and dislike and preferences.

People told us they knew how to complain. One person said, "I don't have any complaints and if I had any concerns I would be happy to mention them to staff". A relative confirmed they were aware of the complaints procedure. We saw the provider had a complaints policy in place. When needed the provider had responded to complaints in line with their policy.

Requires Improvement

Is the service well-led?

Our findings

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of reportable incidents that had occurred at the home. This included a safeguarding concern. The provider had also failed to notify us about the alleged abuse incidents that had not been raised as safeguarding. This meant we could not be assured the provider was notifying us of significant events within the home so we could check to ensure appropriate action had been taken.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems that were in place to review and monitor care were not always effective. We saw care files were reviewed; however there was no evidence that changes to people's care had been made in response to these reviews. For example, an incident had occurred where one person had been injured. The persons care plan had not been reviewed and no action had been taken to reduce the risk of this happening again.

There were some systems in place to monitor the quality of the service, however further improvements were needed. For example, we saw accident and incident and other audits had been introduced, however these had not been fully completed yet so we could not be sure they were effective. We saw that some of the new systems that had been recently introduced had identified areas of concern. For example on the medicines audit we saw that gaps in medicine administration records had been identified. We saw on the action plan that this was to be discussed with the relevant staff members. As the audit had recently been completed this action had not been completed yet. The manager talked through the process that would take place.

There was a new manager in post. They confirmed they had started the process to register with us. Staff and relatives we spoke with were positive about the new manager. One staff member said, "They are great and approachable, I have no concerns with the appointment". A relative said, "I think it's a positive step". Staff told us since the manager had been in post they had had the opportunity to meet and felt listened to. One staff member said, "I had my one to one, I had no concerns but felt listened to and supported if I needed anything". Another staff member said, "We have a staff meeting planned for next week, I feel we are listened to now". We saw that the rating from the last inspection was displayed within the home in line with our requirements.

The provider sought the opinions from people who used the service. We saw that annual satisfaction surveys were completed. The information was collated and used to bring about changes. The last survey was completed in July 2016 and there were no areas of improvement identified in the areas that were looked at.

Staff we spoke with were happy to raise concerns and knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "I would do this if needed, I would be supported by the manager". We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns and were confident they would be dealt with.

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 Registration Regulations 2009 Notifications of other incidents The provider was not always notifying us about significant events that had occurred in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed in a safe way. When incidents occurred no action was taken to ensure these were reviewed and avoid any reoccurrence. When people had behaviours that may challenge staff offered an inconsistent approach. Staff did not always have information about moving and handling to ensure people were supported in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential abuse as concerns were not investigated or reported appropriately.