Amson Care Ltd

Shiels Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 February 2018 and was unannounced.

When we completed our previous inspection on 16, 22 and 24 December 2015 we found significant failings in the service. The service was rated inadequate and placed into special measures. The follow up inspection on 28 and 29 June 2016 found improvements had been made to meet regulations and the service was taken out of special measures. However, improvements were needed to ensure risks associated with people's health conditions were assessed and measures put in place detailing how these could be reduced. Additionally, people were at risk of not receiving consistent care, as staff did not have clear guidance to follow, including where people's behaviour was challenging to staff to manage. At this time, managing behaviour that challenges was included under the key question responsive. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework, this topic area is included under the key question of safe. Therefore, for this inspection we have inspected this key question and the previous key question responsive to make sure all areas inspected validate the ratings.

At this inspection we found the required improvements identified in June 2016 had been made. However, we found further concerns in relation to staffing numbers allocated to the Coach House. These were not sufficient to meet people's needs. We also continued to find staff were not clear about the application of the Mental Capacity Act (MCA) 2005 legislation and when this should be applied. At least 10 people using the service had been diagnosed with advanced dementia and or mental health issue, which affects their capacity to make decisions. There was no documentation in place to reflect how these people were supported to make day-to-day decisions. With the exception of best interest decision instigated by the Dementia and Intensive Support Team (DIST), there was no evidence to show there had been consultation with people's family or other professionals, when making decisions about their care and treatment. We also identified not all staff had received training to ensure they had the right skills and knowledge to meet the specific needs of people using the service.

Before this inspection, we received information from a person using the whistleblowing process raising concerns about poor care, people having to wait for medicines, issues about the environment and poor infection control practices. At this inspection, we found people were happy with the care and support they received and they were positive about the staff. We saw people were clean, dressed in appropriate clothing, their nails were clean, hair was tidy and their glasses were clean. People were receiving their medicines when they needed them. Although infection prevention and control policies were in place, these were not always followed by staff to ensure essential elements of general cleaning were undertaken. Cleaning schedules were in place but were not being used effectively to keep the premises clean.

Shiels Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Shiels Court Care Home is one adapted

building, with a self-contained dementia unit, referred to as the Coach House. The service accommodates up to 43 people. There were 37 people using the service at the time of our inspection, 11 of whom were living in the Coach House.

There is 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.

Systems and processes were in place and understood by staff in relation to protecting people using the service from harm or the risk of harm occurring. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. Recruitment practices ensured potential employees were suitable to work at the service. Staff understood their responsibilities to report incidents that occurred in the service. The registered manager had taken appropriate action to investigate where things had gone wrong and referred incidents to the appropriate people, including the safeguarding team. Where people had no next of kin to advocate on their behalf, social workers and advocacy had been sought.

Risks to people's health and welfare were identified, checked and managed to keep them safe, including regular checks on the environment and equipment. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. Where risks to people's welfare were identified requiring specialist input appropriate referrals were made to other health professionals. People had been provided with technology and equipment, such as sensor alarms and pressure relieving equipment, to promote their independence and help them to stay safe. Systems were in place to manage people's medicines safely.

People's needs were assessed before they came to stay at the service. Information was sought from the person, their relatives and other professionals involved in their care. The registered manager and staff spoke passionately about the people they supported and knew their care needs well. The service was in the process of transferring people's care plans onto a newly implemented electronic care planning system, which will ensure staff have access to information that is up to date and accurate.

People were provided with sufficient to eat to stay healthy and maintain a balanced diet. People had access to health care professionals, when they needed them. The registered manager had worked hard to develop a good working relationship with the GP and district nurses.

People can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The authorisation procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). Appropriate DoLS authorisations for 13 people had been submitted to the local authority to lawfully deprive them of their liberty for their own safety, however only four of these had been granted to date. The registered manager had contacted the local authority to chase these authorisations.

Staff were kind and caring and had developed good relationships with people using the service. Relatives confirmed staff were caring and looked after people well. Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement. People were supported to make choices and decided how they spent their day. However, outcomes for people were different for those who lived the Coach House. Staffing numbers and the lack of experience of care staff in the Coach House did not always ensure people were provided with the emotional support they needed.

During the two-day inspection the activities member of staff did not spend any time in the Coach House. There were missed opportunities to engage with people and reduce their anxieties and /or distress.

Staff were aware of the importance of ensuring people's dignity was respected at all times, however we observed on a number of occasions where staff failed to do this. People d personalised care that was responsive to their needs. We saw positive examples, where the pet rabbits were used to help calm and settle a person showing distress and anxiety. People and relatives felt staff went out of their way to provide activities.

People, their relatives and staff spoke positively about the provider and registered manager. Staff felt supported. Staff described both the provider and registered manager as approachable, very hands on, supportive and demonstrated good leadership, leading by example. Concerns or complaints were taken seriously, explored and responded to.

The providers systems for assessing and monitoring the service was not consistently identifying where improvements were needed. The monthly dependency audit had not identified that the staffing arrangements were insufficient to meet the complex needs of the people living in the Coach House. Neither had the infection control audits identified high level cleaning, such as extractor fans was not being carried out as specified in the cleaning schedules.

Significant improvements have been made at the service, largely in relation to refurbishing the environment and implementing the new care planning system. The provider and registered manager had a clear understanding of what needed to happen to improve the service. This included delegation of clear responsibilities across the management team to drive the improvements identified in their own action plan and as identified by us at this inspection.

This is the second time the service has been rated Requires Improvement.

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 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 consistently safe

Although sufficient staff were employed, the deployment of staff across the service was not equitable and did not support people's emotional wellbeing.

Systems were in place to assess, manage and respond to risk. Staff demonstrated a good awareness of safeguarding procedures and how to recognise and report signs of neglect or abuse.

Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

Effective systems were in place to ensure the safe management of peoples medicines. People received their medicines when they needed them and in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had not received training to ensure they had the necessary skills and knowledge to carry out their roles and meet the specific needs of people using the service.

Significant improvements have been made to the premises. Adaptations to the building and decoration have improved the environment, particularly for those with dementia, to help them find their way around and maintain their independence. There is a continued refurbishment plan in place.

Although staff had attended training, the requirements of the Mental Capacity Act (MCA) 2005 were not understood. People were not supported to have maximum choice and control over their lives.

People were provided with enough to eat to maintain a balanced diet. People received support to maintain their health and had access to appropriate healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring

People's privacy was respected, but their dignity was not always maintained.

People and their relatives were complimentary about the attitude of staff. Staff were kind and caring and had developed good relationships with people who used the service.

People were not always supported to make choices and decide how they spent their day. Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement.

People were provided with the care support and equipment they needed to stay independent.

Is the service responsive?

Good

The service was responsive.

People's care plans had been developed from the initial assessment and covered all aspects of their care and how they preferred to have their needs met.

Concerns or complaints were taken seriously, explored and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although regular audits were taking place to assess the quality of the service these were not used effectively to identify where improvements were needed.

There was an open and positive culture in the service. Communication between staff and the management team was good. Staff felt supported and valued.

People, their relatives and staff were asked for their views and involved when making decisions about ways to improve the service. Their views were listened to and acted upon.

The registered manager had developed good working relationships with other health professionals, agencies, and charities such as the district nurses, Dementia and Intensive

Support Team (DIST) and Edith Ellen Foundation.

Shiels Court Care 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 took place on 13 and 14 February 2018 and was unannounced.

On the first day of the inspection the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion their expertise was in dementia care. The second day of the inspection was completed by two inspectors.

Before the inspection, we reviewed information available to us about this service. This included an action plan implemented by the Infection Prevention and Control (IPAC) team following a visit to the service on 08 March 2016, and reviewed in 14 June 2016. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of whistleblowing concerns, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We spoke with five people who were able to express their views, but not everyone chose to or were able to communicate effectively or articulately with us. Therefore we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five relatives, a social worker and an independent advocate who were visiting the service during our inspection. We also spoke with six staff, laundry assistant, the deputy manager, registered manager and the provider.

We looked at five people's care records, three staff files and reviewed records relating to the management of medicines, complaints, staff training, records in relation to maintenance of the premises and equipment and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People, staff and relatives told us that there were sufficient numbers of staff to meet the needs of people using the service and to keep them safe. However, we found that although there was enough staff available in the main unit to meet people's needs, this was not the case in the Coach House. The Coach House is a separate unit, which supports up to twelve people who have complex needs, including advanced dementia and mental health. On both days, there were two staff in the Coach House, one of whom was a team leader. The team leader was administering medicines, which left one member of staff trying to support eleven people. People were agitated, shouting out and trying to exit the unit. Staff were under pressure to manage the situation. One person was observed slumped in a recliner chair with their feet hanging off the footplate and was having difficulty breathing. Food around their mouth and on their shoulder reflected they had not long eaten their meal. Their care records reflected they needed to be sat upright for meal times and up to 30 minutes afterwards as they were at risk of choking. There was no staff available in the dining room to re position this person. We found two staff coming from the staff room and requested they reposition the person to make them comfortable and avoid the risk of choking.

In contrast, on both days there were five staff and a senior supporting 25 people in the main house. Staff were visible in communal areas or nearby and if people called out staff responded promptly. One member of staff told us, "Yes, I think we have enough staff on shift, people are given the care they need and although we are busy we manage well." Another said, "I think there is enough staff, we all work well together and help each other on the different units."

The registered manager told us they used a national dependency tool to calculate staffing levels and this was reviewed monthly. If people's needs changed, staffing numbers were adjusted accordingly. We looked at the dependency assessment, which reflected 10 people residing in the Coach House were assessed as being a very high dependency risk. The main unit in contrast had seven people who deemed to be a very high risk, with 14 people assessed as medium. The registered manager told us current staffing levels were nine staff across daytime hours, with four staff at night. Two staff were allocated to the Coach House with one member of staff floating between the two units. The distribution of staff across the service, in particular the Coach House was highlighted following our inspection in December 2015. At the last inspection in June 2016, the registered manager told us staffing ratios had been increased, to include a floating member of staff allocated to the Coach House. Staff in the Coach House told us, although they were supposed to have a floating member of staff at busy times this did not always happen.

This was a continued breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments from people living in the main unit and their relatives confirmed there were sufficient staff available on this unit to meet their needs and to stay safe. One person told us, "I feel safe here more than anywhere else because I have the staff and if I need anything, I can press my buzzer and they [staff] come." People told us, there was always staff available at night if they needed them. Comments included, "I had a 'funny turn' during the night, and I rang my bell and they [staff] came straight away," and "I like it here, I

have staff who make me feel safe, and the night staff check on me to make sure I am okay." One relative told us, "There is definitely enough staff, they all seem very pleasant. I noticed this morning how much the staff do for people." Another relative commented, "I visit two or three times a week to take my [Person] out and whenever I am here there are always enough staff." Other comments included, "Yes, there is always enough staff, always someone around to help if you need it," and "Never see people having to wait to be helped."

Before this inspection, we received information from a whistle blower raising concerns about poor hygiene, people's clothing going missing and poor infection control practices. Although, people and their relatives told us, "The home is clean" and "The home and my [Persons] room is clean and tidy," they confirmed there was ongoing issues with the laundry and missing clothing. One person told us, "The laundry here is terrible, you put clothes into be laundered and you don't get them back." The provider confirmed there has been an ongoing issue with people's clothing going missing and was looking at ways to minimise this, including permanent ways of marking clothing. The laundry was in the process of being re modelled to include, dirty and clean areas, sluicing equipment and new washing machines. The upheaval had added to people's clothing being mixed up, or mislaid. Shelving was being installed to create more space for separating people's clothes.

The local authority IPAC team had supported the registered manager to improve infection prevention and control practices in the service. Regular infection control audits were now taking place, and staff were wearing appropriate Personal Protective Equipment (PPE), such as aprons, hair nets, and gloves when preparing food. The Food Standards Agency (FSA) had given the service a food hygiene rating of five at their recent inspection. The Food Standards Agency is an independent Government department, which rates services reflecting the standards of food hygiene, five being the highest. Although, there has been significant improvements to the environment we found bathroom vents and extractor fans had not been cleaned for a long time and were clogged with thick dust in at least three people's en-suite bathrooms. One of the towel rails was rusty and one person's bedding was ripped in two places. Four domestic staff were employed and cleaning schedules were in place, however these were not always being followed. This had not been picked up in the services most recent infection control audit dated October 2017.

People told us they felt safe living at Sheils Court. One person told us, "I feel perfectly safe here, you can't fault it really. If anything bothers me, I can talk to someone about it." Other comments included, "I do feel safe living here, the doors are locked, which keeps me safe" and "One time my electrics went out during the night, which worried me, but staff told me not to worry, they came round every half an hour to check on me."

Staff confirmed they had received safeguarding adults training and were aware of the different forms of abuse. They demonstrated a good knowledge of safeguarding procedures and knew whom to inform both within the organisation and to outside agencies if they witnessed or had an allegation of abuse reported to them. One member of staff told us, "I would report anything to my manager and I know that I can report to the Council or Police if I have to." Another said, "I know that I can report to my manager in the first instance but I also know to call the safeguarding team or even the police if I needed to." The registered manager was aware of their responsibility to liaise with the local authority were safeguarding concerns had been raised and such incidents had been managed well. For example, they had referred an incident where a person using the service had slapped another person. They had also taken action to prevent this from happening again, by referring the person to the GP who had reviewed and changed their medicines to help manage their anxieties.

Relatives told us their family members were well cared for and safe at Shiels Court because there was good security in place. One relative said, "My [Person] is safe here, I never worry about them being here." Other

comments included, "Staff make sure my [Person] is safe, they really look after them" and "Safety is not a problem, staff keep me informed of any changes in my [Person]." We saw people were cared for in a safe environment and appropriate monitoring and maintenance of the premises and equipment was ongoing. External companies were contracted to carry out regular checks on fire system, electrics, including Portable Appliances Testing (PAT) and pest control. Records showed that equipment such as hoists and slings had been serviced regularly in accordance with the Lifting Operations Lifting Equipment Regulations 1998 (LOLER)

We looked at five people's care records and found systems were in place to identify and reduce the risks to people using the service. Risks associated with people's health and welfare, such as falls, nutrition, dehydration, incontinence, developing pressure wounds and managing behaviour that challenged had been assessed and guidance written for staff to follow to minimise the risk of harm. Staff were clear that the service had a 'no restraint' policy in place and were able to talk through 'distraction techniques' used to deescalate people's behaviours when anxious or distressed. Where required equipment, such as pressure relieving equipment was provided. Staff carried out routine checks to ensure these were working and set at the correct pressure for the person's weight. Technology, such as senor matts were being used to reduce risks of falling, which alerted staff if a person had got out of bed.

Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. For example, we observed staff in communal areas assisting people to mobilise or transfer using equipment, such as hoists or walking belts where they were unable to weight bear. Staff were patient and calm and gave people clear verbal prompts when needed. However, on one occasion, we saw two staff assisting a person to walk from the dining room to the lounge using a walking belt. The person was not fully weight bearing on their feet and the two staff were holding them up whilst walking. Staff were following the information in the persons moving and handling plan, however the registered manager told us the person's mobility fluctuated from day to day and staff assessed their ability before each transfer. They told us this was the advice of the Occupational Therapist, but could not locate the recommendations made following the OT assessment. Therefore, it was not clear how staff were assessing the person's ability to weight bear and placed the person and staff at risk of injury. The registered manager recognised information about people's needs was difficult to trace, but explained they were in the process of transferring all information onto an electronic computer care planning system. Once completed they told us, people's care records will be held in one place and all information about their care will be able to be found with ease and clarity.

We looked at three staff files and found staff were recruited safely. Appropriate checks had been carried out to ensure they were safe to work with in the service. Checks included an application form with full employment history, proof of identity and satisfactory references. The provider had also undertaken a Disclosure and Barring Service (DBS) checks on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults.

People told us that they received their medicines when they needed them. Comments included, "The staff help me with my tablets in the mornings, as I can't medicate myself" and "I have lotion on my knee every day." Staff had access to and were aware of the provider's policy and procedures for managing medicines. Only senior staff or team leaders who had been trained and assessed as competent administered people's medicines. We observed a senior completing the lunchtime medicine round. They were patient and interacted with people in a positive way. They took time to explain what the medicine was for, gave people a drink of their choosing and gave people their tablets one at a time, ensuring those at risk of choking sat upright and had a drink. The senior asked people if they had pain and offered pain relief as required. A person complained of pain in their hand. We saw from their chart that they had been administered

paracetamol on two consecutive days. The senior checked with the person and agreed to make an appointment with their GP to investigate why they were experiencing pain.

Random sampling of people's medicines, including controlled drugs against their records confirmed they were receiving their medicines. People prescribed 'as necessary' medicines, such as analgesia, had specific plans in place, detailing their medicines and how they preferred to take them, for example, with a glass of squash. Body maps showed the location for the application of creams and ointments. The recording on these maps was consistent with people's prescriptions, and there were no gaps. Where medicines needed to be used within 28 days of opening, for example eye drops, staff had written opening dates on the bottles or boxes so that staff would know when they needed to be discarded. Checks were being made twice daily of the temperature if the medicines room and fridge, which ensured medicines were being stored at the correct temperature and remained effective. Unused medicines were being disposed of appropriately, a record kept and returned to the pharmacy.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in June 2016 identified that people's ability to make informed decisions about their care and where required treatment was not always documented, in line with the requirements of the Mental Capacity Act (MCA) 2005. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. At this inspection, we found one person's care records contained information showing that due to their mental health and refusal to take their antipsychotic medicines, a best interest meeting had taken place. Agreement was reached that the person would be offered their medicines, but if they refused, they were to be administered covertly (disguised in food). However, the Dementia and Intensive Support Team (DIST) had instigated this meeting.

We found there continued to be a mixed understanding of the MCA. The registered manager and deputy were unclear about when a MCA assessment should be completed. Although, they both understood people must be assumed to have capacity to make decisions unless proven otherwise, none of the people's records we looked at contained evidence that their capacity had been assessed. The staffing dependency tool reflected 17 people had been assessed as very high risk, at least 10 of which had advanced dementia and or mental health issues, which affected their capacity to make decisions. There was no documentation in place to reflect how these people were supported to make day-to-day decisions. With the exception of the best interest decision described above, there was no evidence to show there had been consultation with people's family or other professionals, when making decisions about their care and treatment and evidencing if this was in their best interests.

Although records showed that staff had attended MCA training, those spoken with did not have a good understanding of this legislation and when this should be applied. Comments from staff included, "I am not sure if I have had training." When asked what they thought lack of capacity meant, staff responses varied, one member of staff correctly stated, "You should assume capacity unless proven not." Another commented, "A person is unable to make informed decisions," but was unable to explain what they should do to support this person to ensure they were acting in their best interests. A third member of staff told us, "Means they can't do things."

This was a continued breach of regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a supervisory body for authority to do so. We saw appropriate DoLS authorisations for 13 people had been submitted to lawfully deprive them of their liberty for their own safety, however only four of these had been granted to date. One was an urgent application,

which had been submitted in August 2016, but had not yet been authorised. The registered manager told us the local authority had been very slow in carrying out the assessments and had chased the applications; however, they had no record to reflect they had done so. The registered manager agreed they would chase the local authority again and keep a record of contact and when the DoLS were processed.

Staff told us they had received training, both via classroom and computer based learning which gave them the knowledge, skills and confidence to carry out their roles. Training had included National Vocational Qualifications in health and social care at various levels, according to their job role. Comments included, "I have completed all the mandatory training required, I did that before I worked on the floor." Another said, "I have completed all training as part of my NVQ and I know we have refresher training coming up soon too." However, the deputy manager provided a training matrix, which was not up to date and showed several gaps in staff training. The providers Statement of Purpose states the care and support services provided at Shiels Court included Alzheimer's, palliative care, Parkinson's disease, schizophrenia and visual impairment. Not all staff had not received training to support people with these conditions. The registered manager recognised there were some gaps and confirmed they had been booked dates for training in the coming months for safeguarding, mental capacity and dementia. However, this still left gaps in training relating to people's specific needs, including but not limited to mental health and supporting people with behaviours others found challenging.

This was a continued breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us they had recently completed, 'Preparing to Teach in the Lifelong Learning Sector' (PTLLS) training which enabled them to provide training to staff in house, including overseeing the induction training for new staff. When staff joined the service, they told us, they had received an induction. Three staff files reviewed showed they had completed an induction, including the Care Certificate. The Care Certificate was developed jointly by the Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. Staff told us, as part of their induction they had spent time shadowing more experienced staff so that they could learn about people's needs and how best to support them. However, from our observations, new staff were working on their own in the Coach House with minimal support.

In the main unit we saw staff worked well together to ensure they delivered effective care and support to people using the service. Staff told us, working as a team ensured people received care in a consistent way. One member of staff told us, "We all work together as a team and this helps people get the care they need." Another said, "We have a handover on each shift to make sure we know how people are or if there have been any changes."

We observed the lunchtime meal on both days of the inspection. Staff informed us lunchtime was normally at 13.00. We saw people started to arrive and were assisted to tables at 12.55, but lunch was not served until 13.35. This was a long waiting period, but people were provided with drinks whilst waiting and overall the dining experience was sociable. People sat with others talking during the meal. However, we saw meals were plated up in the kitchen and then taken through to the dining room a table at a time. The meals were not covered and brought through the corridor past the laundry access and main reception area into the dining room. This exposed people's food to contamination from harmful bacteria and placed them at risk of food poisoning. We saw that staff consulted with people about what they wanted to eat. Staff offered a choice of meals. Where people required their meals pureed due to choking risks each food item was pureed separately and was placed on their plate in a way that still made the food look appealing. People told us

they enjoyed the food. Comments included, "I really like the food," and "I get more than enough to eat, if I don't like something I can always have something else. There is always plenty of fresh fruit." One person said, "The food is very good here, you have a choice." Another person commented, "Sometimes I like the food, sometimes I don't, but then I am a fussy eater." A relative told us, "The food always looks lovely, they [staff] even offer us a meal when we are here."

People's nutritional requirements had been assessed and their individual needs, including their likes, dislikes and dietary needs were documented. Where required, people had been referred to the Speech and Language Therapy (SALT) services. Their input and advice was clearly recorded and being followed by staff. The provider told us they were in the process of introducing a new computer care planning system to enhance the delivery of care and support provided. Although this new technology had not yet been fully installed, staff carried hand held devices, which linked to the system. The device was programmed to send an alert to staff when a person required care, for example, where a person needed repositioning or required their weight, food and fluid monitoring. On completion, staff logged that they had completed the task. The registered manager told us prior to using the system staff were not properly recording people's food, fluid and comfort rounds. With this system, if the staff do enter information the team leaders and registered manager received an alert, and would follow up why the required care had not been provided. We saw that this system provided accurate information about people's nutrition and hydration needs and calculated a percentage of the person's daily intake. If people had not had sufficient fluids an alert was sent to staff for action to be taken. The registered manager told us this new system meant peoples food and fluid was regularly monitored and ensured they received enough nutrients in the day.

People told us they received support to maintain their health. One person told us, "I have seen the GP when I have needed to, for example, if I get a cold it tends to go to my chest." Another person told us, "I saw the dentist in January and the chiropodist's visits regularly to look after my feet." A third person commented, "I see the doctor, when I need to and the chiropodist." Relatives were confident their family member's health was being monitored and that they were kept informed if they were unwell. One relative commented, "Staff look after my [Person] well, they keep me informed about any changes in their health. They used to get many urine infections, but staff are good at recognising the signs and get treatment at an early stage." Another relative commented, "They are very good at contacting the GP if my [Person] is unwell."

People's records confirmed they had access to a range of healthcare services including the GP, optician, specialist nurses and dietician. We saw advice from health professionals was documented and being followed by staff. For example, where a person was experiencing swallowing difficulties and at risk of choking, they were referred to the SALT team, who prescribed a thickening agent to be added to fluids. This was clearly documented and staff knew to add this to their drinks. Staff told us they supported people to attend health appointments at the hospital, GP and dentist when required. Relatives confirmed this. One relative told us, "A member of staff is always sent to the hospital with my [Person] if we cannot make it." Another relative said, "[Person] needed to go to hospital in an emergency, staff called me to tell me and a member of staff went with them and waited at hospital until we got there."

The provider had made significant improvements to the environment. Adaptations had been made to the building enabling people to move freely around the premises and gardens, including those who used wheelchairs. People's bedrooms had been personalised, for example, one room had been decorated with a Scottish theme, as this was one of their favourite places to go on holiday. One person told us, "I have patio doors in my room that lead out into the garden. I have table and chairs on the patio and I love siting outside in the nice weather." Some of the redecoration had taken place in the Coach House. Each person's door to their room had been painted in a different colour, with a 'door knocker' and hanging baskets outside to give the person the feeling that is was 'their own front door.' We saw this helped people to identify their rooms.

Requires Improvement

Is the service caring?

Our findings

Although staff showed concern for people's wellbeing in a caring and meaningful way, the outcomes for people were different for those who lived in the main unit and the Coach House. The practical arrangements regarding staff experience and numbers in the Coach House did not always ensure people were provided with the emotional support they needed. On both days, when we spent time in the Coach House the carers were trying to manage situations where people, who due to their dementia and mental health were agitated, shouting out and trying to exit the unit. As both staff had only been employed for a short time, they lacked experience on how to provide sufficient support to meet the diverse needs of these people. One relative told us, "What I have noticed is that there a lot of staff from overseas and there can be a problem with communication." We saw the impact of this in the Coach House where a member of staff whose first language was not English, and recently in post, was struggling to interact with a person with communication difficulties, during a period of anxiety, which made the situation worse, before the inspectors and the team leader intervened.

The service employs a person to arrange activities, however, during the two days of our inspection the activities member of staff did not spend any time in the Coach House. This had been identified in a seniors meeting on 15 January 2018, and was a missed opportunity to think of activities that could be used to engage with people and reduce their anxieties and /or distress. The response had been that the 'third member of staff can do the activities.' As already identified a third, member of staff was not always provided and therefore this aspect of people's care was not being met. However, in contrast, in the main unit we saw staff supported people promptly when required. There were positive interactions between staff and people including chatter and laughter, which made a nice and calm atmosphere. Staff were smiling and using humour as they engaged with people. They were friendly, affectionate and showed concern for people's wellbeing. One person told us, "I can talk to the staff and they are kind to me."

Prior to our inspection, we received information of concern about people not receiving appropriate care. Issues were raised about people being left in wet or soiled continence pads, poor personal hygiene and people's teeth not being cleaned. During this inspection, people told us they were happy with the care and support they received and were positive about the staff. We saw people were clean, dressed in appropriate clothing, their nails were clean, hair was tidy and their glasses were clean. One person told us, "The staff are fine, I get on well with all of them, and they get used to me." Another person told us, "The staff are very caring, they speak to me nicely."

The PIR stated the staff encouraged choice and independence by always asking people what they wanted, before carrying out any tasks. However, we found there was inconsistencies in the staff team when offering people choices. For example, one member of staff placed glasses of squash in front of people at lunchtime, without offering a choice of flavours. This same member of staff placed glasses of blackcurrant squash on a table with no people sitting at it, however a different member of staff offered people sitting at another table a choice. Additionally, staff were observed placing aprons on people at meal times to protect their clothing without asking if they wanted an apron or explaining what they were doing, taking people by surprise.

Where people required assistance to eat this was not always carried out in a way that promoted the persons independence and dignity. For example, we saw one person was experiencing difficulty eating their meal, due to arthritic hands. Staff did not intervene and the person took well over an hour to eat their meal. No adapted cutlery or plate guard had been provided to assist this person to eat their meal. Where two people required support to eat their meal, two staff started to support them. Both staff were standing whilst supporting these people, with no interaction. One member of staff was called away and the remaining member of staff continued to support both people, with little interaction with either person.

Staff told us they were aware of the importance of ensuring, peoples dignity was respected at all times. We saw positive examples where staff respected people's dignity, for instance, a member of staff approached a person in the communal lounge, and spoke with them quietly to ask if they required using the toilet. We also saw staff gained people's consent to enter their rooms and provide personal care. Staff knocked on people's doors whether or not they were open or closed, rather than just walking in. However, we observed on a number of occasions where staff failed to protect people's dignity. For example, we saw two staff assist a person to stand. The person's continence pad was on display above the waistband on their trousers. Staff did not notice this or take any action to pull the persons trousers up or cardigan down and assisted the person to walk through the dining room and past others through to the lounge.

Irrespective of the above, people and their relatives told us they received care and support from staff who knew, or were getting to know, them well. The majority of staff had worked at the service for a number of years and people spoke about some of them by name. These experienced staff knew about people's likes, dislikes and preferences, on how they wanted their care and support provided. Relatives told us they and their family member were involved in planning and making decisions about their care. One relative told us, a change in their [Person's] behaviour had started to impact on the quality of their life and others in the home. They had been involved in discussions with the GP and registered manager about their [Person] taking part in a trial for a new medicine to reduce anxiety. They told us their relative had responded well to the drug trial, but the trial had now ended and they were liaising with the GP to find an alternative medicine to manage their anxieties.

Where people had no next of kin to help make decisions about their care, support and where required treatment we saw a social worker and a Mental Capacity Advocate (IMCA) had been involved. We met and spoke with the social worker and advocate during the inspection. They were supporting a person where there were there were ongoing issues about whether or not the person wished to remain at the service.

Relatives were complimentary about the attitude and capability of the staff. One relative told us, "The care is amazing here." Another relative told us, since [Person] has been here I don't worry, because I know they are looked after, which gives me peace of mind. My [Person] can be unsettled especially at sundown, if they are and staff are unable to settle them they will ring me so that I can talk with [Person], and this helps them to settle. The way staff treat my [Person] it's more like a hotel, than a care home. Staff are caring but in a professional away, they treat people like one of their own grandparents." Other comments included, "If I had to come into a place like this I wouldn't mind coming here," and "My [Person] is happy living here."

Good

Is the service responsive?

Our findings

Our inspection in December 2015, identified that risks to people had not been identified and effectively managed. The follow up inspection in June 2016 concluded that although progress had been made action was still needed to ensure care plans contained clear information for staff to follow to ensure people received consistent and appropriate care. At this inspection the registered manager and deputy were in the process of transferring people's care records into the new computer care planning system. Therefore, we reviewed the paper records for five people and found these varied in the level of detail about people's needs.

Two care plans reviewed provided detailed information about the people's care needs, for example managing pressure wound care, continence and how to move and position people safely, including the type of equipment and size of sling. However, information in the other three care plans was not always easily found as this was held in different folders; therefore, it was difficult to assess how well these people's needs were being met. However, the registered manager had very good knowledge of people's needs and was able to explain how these were being met. This, combined with the continuity of an existing staff team meant staff were aware of people's needs, more by knowing the person, than from their care records. This was supported in conversations with people's relatives. They confirmed their family members received consistent personalised care and support. Comments included, "They [staff] are incredible how they manage my [Person]. They look past the behaviour and look at the person," and "Staff know [Person] so well and they are so caring."

Before people began using, the service an initial assessment had been completed to make sure that their needs could be met and if the person would be compatible to live with the existing people living at Shiels Court. Information was sought from the person, their relatives and other professionals and gave them the opportunity to talk about how they would like their care and support delivered. Relatives confirmed they had been involved in the initial planning of their family members care, and were continuously consulted. One relative told us, "They [staff] always ask for our opinion and involve us with any bits of [relative] care."

The existing care plans were being reviewed monthly, or sooner according to their clinical needs. Where changes in people's needs were identified these were responded to promptly. For example, one person admitted to the service from hospital with pressure ulcers had lost weight and was immediately referred to the dietetic service. Their care plan reflected a dietetic nurse completed a telephone assessment of the person's needs and recommended staff continued with the diet plan already implemented on moving into Sheils Court. Because the person was eating a fortified diet with added foods such as cream, butter, and milk to their meal and drinks, plus snacks they had gained weight. Where another person had been diagnosed and registered as partially sighted arrangements had been made to obtain talking books as they had been an avid reader.

Overall, we found staff responded to people's needs promptly. For example, throughout the first day of the inspection one person in the main unit was constantly walking around the service and showed increasing signs of anxiety and distress. The activities member of staff told us, "[Person] loves the pet rabbits and

holding them helps calm their mood." We observed them speak with the person asking if they wanted a cuddle with the rabbit and handed one of the rabbits to them. The person agreed, and became calm and settled for at least 30 minutes whilst stroking the rabbit.
Relatives told us they felt the service went out of their way to provide activities relevant to their family member's needs. For example, one relative told us, staff had had accompanied their [Person] to a family wedding, which enabled the family to enjoy the celebration together which "Gave us a day of memories with Mum."

Activities were provided on an individual basis and in groups. An activities member of staff told us, people were encouraged to go on outings along with families to areas and places that they wanted to visit. One person told us, "I go out on trips to places like the cinema, boat trips and Cromer seaside. We went to the sea life centre and had fish and chips." Another person told us, "We have nice gardens, we have a barbeque now, they [staff] have thought of everything." Other comments included, "I take part in activities, such as cooking and we made decorations for Christmas," and "I do sewing, go out on trips and we went to see Cinderella recently." However, one person commented, "It is a very good service, but I do get bored sometimes, as there isn't much to do."

The activities person told us they provided a wide range of activities, based on discussions with people using the service about their likes and preferences and hobbies. These included, arts and crafts, baking, outings to Wildlife Park, and family events, such as barbeques in the nicer weather. We saw people taking part in an arts and crafts activity, which was themed around Pancake Day and Valentine's Day. People were engaged in the activity, and were having fun. The activities person was quick to notice when people started to lose interest and encouraged them to try an alternative activity.

People and their relatives told us they were able to give their views and raise concerns or complaints. One person told us, "If I have any concerns, I just tell them straight. I know the manager and they have a second in charge that I can speak with if I have any concerns." One visitor told us "I think this is the best place for my friend, they are treated very well. If my friend wasn't being treated right or anybody else I would speak with the manager." Staff told us they were aware of the complaints procedure and knew how to support people to make complaints if required. The registered manager confirmed concerns or complaints were taken seriously, explored and responded to. The complaints folder showed there had been four complaints raised about the quality of the service since, since our previous inspection in June 2016. We saw these had been fully investigated and an apology provided to the complainant. For example, a relative had made a complaint that their family member had no tea one afternoon after their visit. The registered manger investigated, spoke with all staff and provided a written apology. The relative was happy with the action taken.

At the time of our inspection, no one using the service was nearing the end of his or her life, and therefore we were unable to assess how this aspect of the service was managed. The registered manager told us, one person had recently been discharged from hospital to Shiels Court on an end of life care pathway. They had been very poorly, however, since admission their health had improved. We saw end of life medicines had been prescribed and obtained to ensure the person would have a comfortable and pain free death should their health deteriorate. We checked and found these medicines were in date and accounted for. The PIR stated the registered manager had been working alongside the district nurses to introduce a six steps end of life program for staff to follow to ensure people received good palliative care, when this was needed. Where it had been agreed, people had a Do Not Attempt Resuscitation (DNAR) orders in place. A DNAR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR).

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in June 2016 identified whilst some audits were completed to check the quality of the service, further action was needed concerning overall governance. At this inspection, we saw audits were being undertaken on a regular basis and external companies were employed to review fire systems and lifting equipment. However, the audits were not always identifying where improvements were needed. For example, the monthly dependency audit had not identified that the staffing arrangements were insufficient to meet the complex needs of the people of the people living in the Coach House. Neither had the infection control audits identified high level cleaning, such as extractor fans was not being carried out as specified in the cleaning schedules.

The provider told us they spent a lot time at Shiels Court and had oversight of what was happening on a day-to-day basis and overseeing the continuing maintenance of the premises. They provided examples of reports completed after sampling key areas of the service and speaking with people, staff and any visitors. These highlighted things that had gone well and where further improvements were needed. However, the provider agreed these needed to be more in depth to provide a wider overview of how well the service was performing against the fundamental standards of care and meeting legal requirements. The provider was aware of the importance of forward planning to ensure the quality of service they provided could continue to develop. The provider told us, following the inspection in December 2015, they had developed a four year plan to bring the service up to standard. We acknowledged significant improvements have been made at the service, in the last two years. The provider had a clear understanding of what needed to happen to continue to improve the service, including the challenges such as an ageing population with changing needs at the end of their lives and rising costs of running a care service.

The registered manager told us they had an open door policy. This was confirmed in conversations with people, their relatives and staff. They were particularly positive about the registered manager and the provider. One relative told us, "The provider and registered manger were really supportive when I was moving my [Person] into the service. They helped me to sort the funding issues. The provider gave me their personal number to contact them if I had any questions. They were really good." Another relative told us, "The manager is very approachable and will always make time for us." Staff told us there was good communication between the management and themselves. They told us the provider and registered manager were approachable, and supportive. Comments included, "I feel very supported by the manager, I can go to them with anything and they listen," and "They [registered manager] are very supportive and will listen." The registered manager told us they spent time working on the floor staff so that they could monitor day-to-day culture in the service. They said, "I try to lead by example, if I have a happy staff team, I have happy residents. There is not a job I wouldn't ask staff to do that I would not do myself." Staff told us they felt the registered manager demonstrated good leadership and set an example of how care should be provided.

Staff told us they felt well supported and confirmed they received regular supervision. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Staff told us if they needed additional support, this was provided. For

example, one member of staff told us they were dyslexic. They had been provided with a handset where they are able to speak into and record the support they have provided to people, instead of having to write this. Staff told us and records showed that they attended regular staff meetings where they were able to share ideas and were kept updated on changes in the service. The minutes of staff meetings showed that the outcome of incidents, safeguarding concerns and complaints were discussed. The registered manager and staff told us there were open and frank discussions about incidents at these meetings about what went wrong and what was needed to make the required improvements.

Staff said they were happy working at Shiels Court and were positive about the improvements made, but were less clear about the vision and values of the service. One member of staff described the culture as 'homely'. They told us. "Staff are very caring, they go above and beyond what is needed to support people." Staff spoken with were unaware that the provider's statement of purpose contained a set of objectives clearly setting out their vision for the service and what people should expect. Therefore, further work was needed to ensure all staff are aware of these values so that they become embedded in the service provided.

The PIR stated regular contact was maintained with people's families through meetings, telephone calls and social worker meetings. This ensured an open approach and clarity whereby all parties involved were able to have a say in the care provided. One relative told us, "I would recommend this service 100%, I have no issues. My [Person] has been here about two years and in that time, I have seen many improvements. They [Provider] is constantly decorating; they have done all the outside and now focusing on the interior. I have not experienced any poor practice, I think the staff are well trained, there are always seniors staff available if I need to ask anything, and they seem knowledgeable about the people in the home. I feel they know [Person] as well as we [the family] does."

The registered manager had worked well with other professionals and agencies, to provide joined up care, including the Edith Ellen Foundation. The Edith Ellen Foundation is an independent volunteer run charity, which aims to improve the daily lives of residents and families using care services. This had proved a valuable support resource for obtaining a physiotherapist for a person using the service. The registered manager told us they had worked hard to improve relationships with the district nurses and GP surgery. They had weekly meetings with the district nurse team to discuss people's care needs and how they could work together for the good of the service. As well as twice weekly visits from the GP they agreed a task day, where referrals were made and discussed with regards to obtaining other health professional advice such as physiotherapist, dietician's, mental health and occupational therapists. The provider had also signed up to a shared protocol working with the police for Safer Homes and Vulnerable Adult Protection (SHAVA). This is a joint working protocol for responding to adults going missing from care homes. This included completion of a Resident Family Assessment form; with attached photograph to be handed to police should a person go missing, however, none of these forms had been completed.

The PIR stated families were encouraged to leave reviews on how their visit went and generally, what they feel about the home. Additionally, questionnaires were handed out to obtain feedback on the quality of the service. Where people were unable to complete these, they were sent to the person's families asking for their comments. People and their relatives confirmed they were encouraged to share their views and provide feedback about the quality of the service. The PIR contained the results of feedback from people and their relative's questionnaires. Comments included, "Staff are very caring, always willing to listen and there is always somebody on hand," and "New management have improved the home drastically. Food has improved and portions are very generous. The home feels like a home from home and not a hospital. Staff go the extra mile."

During the inspection, we saw an assortment of thank you cards from people's families expressing their

gratitude to the staff for the care and kindness shown to their family members. One relative commented about the fantastic care provided to their [Person] and how much the family had appreciated this. Other compliments included, "Thank you lovely carers, and thank you to you and all your team," and "Thank you all staff who cared for [Person] and all the care and support you gave them."

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 11 HSCA RA Regulations 2014 Need for consent People who use services and others were not protected against the risks associated with giving their consent to care, support and where required treatment. This was because the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services and others were not protected against the risks associated with This was because sufficient numbers of staff were not deployed to ensure people's needs were being met. Staff did not have adequate training to meet the specific needs of people using the service. Regulation 18 (1) (2) (a)