Shipley Hall Limited

Shipley Hall Nursing Home

Inspection report

The Field
Shipley
Heanor
Derbyshire
DE75 7JH

Tel: 01773764906

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Shipley Hall is a nursing and residential care home providing personal and nursing care to 18 people aged 65 and over at the time of the inspection. The service can support up to 30 people. Accommodation was provided in a traditional property across three floors, with communal areas.

People's experience of using this service and what we found
There was limited governance and oversight of the service and the provider was not meeting the required condition on their registration for a registered manager. This impacted on the day to day management of the service and in regular auditing and quality checks.

Audits which were in place were not effective. Accidents and incidents were not always reviewed and thoroughly analysed to reduce the possibility of similar incidents reoccurring. Other audits provided the incorrect information meaning equipment was not replaced in a timely manner.

Risks associated with people's care and specific health conditions, for example Parkinson's or diabetes had not always been identified, mitigated and monitored.

Staff had not received the required training for their roles. There were times of the day when staff were not available to support people in a timely manner, this was because tasks were not allocated effectively.

Potential safeguarding concerns in the service had not been reported or responded to effectively.
Staff did not always feel listen to or supported in their roles. Seniors and nurses were required to manage the home along with completing their caring duties.

Relatives told us that staff were very caring, compassionate and knew people well.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 14 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about governance and people's levels of care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shipley Hall on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, staff training and management of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Shipley Hall Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was completed by one inspector and a nurse specialist. A nurse specialist has nursing knowledge to review these areas of the service.

Service and service type
Shipley Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We spoke with local commissioners and health care professionals and used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with eight members of staff including the provider, nurses, senior care workers, care workers, domestic staff and the chef.

We reviewed a range of records. This included four people's care records, incident reports and multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We also contacted four family members by telephone to obtain their view of the care their relative was receiving.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management;
- Risks were not managed to consider all areas of mitigation or to provide staff with detailed guidance.
- There were no risk assessments in place for long term conditions, for example, Parkinson's and diabetes. When people required insulin to manage their diabetes there was no system to monitor their blood sugar levels to ensure their condition was managed safely. We found four people had diabetes and none had a risk assessment in place on how to manage the individuals needs for this health condition.
- Mattresses which showed damage or strike through of urine had not been identified as being a risk factor which could impact on people's skin integrity.
- We found some mattresses were set to the incorrect weight for the person. For example, one Airflow mattress was set to 150kg, however the person only weighed 50kg. Other mattresses were set to the 'comfort level 10' however this was not reflective of the persons weight and could impact on the effectiveness of the mattress to manage pressure care or the persons comfort levels.
- We observed poor moving and handing practices. For example, two people were transferred from a wheelchair. The care staff pulling the people forward and relied on a hand grip for stability and dragging their feet. This meant there was a risk to the service users and staff safety.

Using medicines safely
- Medicines were not always managed safely. For example, one person required patches to manage their pain. These were prescribed every four days, however the medicine administration record (MAR) had been altered to every Monday and Thursday. There had been no consultation with the GP to agree this decision or any possible impact in relation to the effectiveness of the patches.
- Some medical conditions required medicine to be given at a prescribed time. We found the medicine was not given as specified and there was a 45-minute delay in administration of this medicine which could impact on its effectiveness.
- Creams and day to day prescribed applications were not consistently recorded. Some people were prescribed specialist shampoo, this had not been applied as directed. Other people required daily creams. There was no guidance to show staff where the cream should be applied or daily records to confirm the application.

The provider had failed to ensure that people were protected from the risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment; Learning lessons when things go wrong
● Staff were not always training to provide the required support to people.
● Some people expressed themselves with behaviours which challenged and received one to one care from agency or care staff. However, we found there was no behaviour plan to support staff to reduce the risks of their anxiety or how to manage their behaviour. When behavioural incidents had been recorded on a chart, they had not been reviewed to consider any possible triggers or actions which could support staff.
● We reviewed the training matrix and found 10 out of the 20 staff had not completed training in managing behaviours that challenged and 12 out of 20 had not completed the training dementia. This meant staff were not supported in obtaining knowledge about their role.
● The summary sheet which detailed basic information on all the people in the home identified 15 people have a ReSPECT form in place. However, on discussion with staff they were unsure what this meant and assumed it was 'Not for resuscitation'. The ReSPECT form provides an individual plan of the care in the event the persons health needs deteriorated.
● We reviewed the training matrix for this area and found only six staff out of 20 had completed the training in DoLS, consent and palliative care. This meant staff had a lack of understanding in these areas placing people at risk of receiving incorrect care.We found other gaps in the training matrix, meaning staff lacked the support they required in performing their role effectively.
● There was an inconsistent approach to staffing. We found care staff had to juggle between care duties and kitchen work during the morning up to 9.30am and after 3.00pm. This impacted on the number of care staff to meet peoples care needs.

The provider had failed to ensure staff had received the required training for their role. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a process for ensuring that staff were recruited safely. Pre-employment checks had been undertaken prior to staff commencing employment. Staff had Disclosure and Baring Service (DBS) checks in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● The provider had not always taken action to protect people from the risk of harm.
● An incident had occurred in the kitchen, which impacted on a risk to people's meal. No safeguarding referral was raised to ensure there was an open approach to risk and how action to reduce the risks were managed.
● Staff had received online safeguard training, however not all staff we spoke with were aware of all the areas which should be reported.

Preventing and controlling infection
● The provider had ensured most areas had been considered in relation to following the guidance in accordance with managing infections and COVID-19. However, we had concerns in relation to some hygiene practices for equipment. This meant we were not always assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The provider was facilitating visits for people living in the home in accordance with the current guidance and some relatives were essential care givers to enable them to support people using the service.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of oversight and governance arrangements within the home.
- There was no registered manager as required by the providers conditions on their registration with the Care Quality Commission. This meant there was a lack of day to day management of the service and it relied on the nurses and senior staff in addition to their caring duties.
- The provider lacked the effective quality monitoring processes and procedures to ensure the service continued to provide good quality care. We saw when audits had been completed, they had not identified areas which required improvements. For example, the mattress audit stated all were in good working order. However, we identified four which required immediate replacement and mattresses set to the incorrect weight setting.
- Other audits for accident and incidents were not consistent to reflect tends over months, areas of individuals. For example, a repeated issue with the footplates being removed from wheelchairs.
- Care plans had not been consistently reviewed to identify when incorrect or missing information had been recorded. We found missing information regarding health concerns, risk assessments and old information which was contradictory to the persons current needs. This put people at risk of not receiving the correct support as staff did not have all the necessary information.
- Information for new admissions was not always detailed or shared with staff to ensure the care was provided in accordance with the person's needs. For example, the providers care plan reflected information the person should be cared for in bed, however the hospital assessment stated support with mobility and a different use of equipment. This meant the correct care was not provided and impacted on the persons care experience.
- There was no continuous learning from incidents or audits. Staff did not receive formal handovers and information was not clearly detailed to enable staff to receive timely information about people's needs.
- The providers policies were not always up to date or reflective of updated guidance and best practice. For example, the complaints policy was not consistent with referring people or relatives to the appropriate channels. We found policies and COVID-19 guidance was not always updated. This meant the current information not be shared or followed.

The provider had failed to ensure that systems and processes were in place to drive quality and improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not enabled staff, people and their families to be involved in shaping the service.
- Staff felt they had not been listened to in relation to the levels of staff and the management support they required. Supervisions had not been completed to provide staff with support and guidance for their roles.
- There was a mixed feeling from relatives. Some felt well informed and had the opportunities to visit in accordance with the visiting guidance. Others felt there was a lack of communication and this could be improved to provide more opportunities to discuss the care of their relative.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The culture of the home had been impacted by the lack of management support. Staff felt they lacked the consistent guidance for their role and in the running of the home.
- Relatives we spoke with all spoke highly of the kindness of staff. One relative said, "Staff really care for [Name] and go the extra mile." Another relative commented, "[Name] is always clean and tidy when I go, and staff know them well."
- People had a choice of meals and all dietary needs were detailed on a written sheet to support staff in ensuring people received the correct diet and for their needs.
- The provider had sent us notifications which related to events at the service. However, as not all incidents had been recorded, we could not be assured we had received all the notifications in relation to all the incidents which had taken place

Working in partnership with others

- Staff within the service worked in partnership with other professionals such as GP's and speech and language therapists to support people to access healthcare when needed.
- The service had acted promptly when there had been concerns about people health and the relevant health professional had been contacted to seek advice and support.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not in place to support long term health conditions. Mattresses and equipment had not been replaced, to ensure the they were effective. Some medicine management concerns were raised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the required training for their roles.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not meeting their condition for a registered manager. There was limited oversight and governance. audits were not effective in managing improvements. Care plans were out of date and lacked details about peoples current needs.

The enforcement action we took:

We have issued an warning notice to the provider