Miss C McCrory

# Shipbourne House Limited

## 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? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

Shipbourne House is a residential home that provides care, support and accommodation for up to 24 older people. At the time of our inspection there were 15 people living in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

Although staff worked hard to ensure people were kept safe, there were not always enough staff to support people in a timely manner and meet their needs appropriately. Identified risks to people's safety were recorded on an individual basis and there was guidance for staff to be able to know how to support people safely and effectively.

Medicines were managed and administered safely in the home and people received their medicines as prescribed.

Staff were experienced and knowledgeable in their work and new members of staff were required to complete an appropriate induction. However, some training was out of date and staff did not feel supported by the registered manager or the operations manager.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The registered manager and senior staff ensured the service operated in accordance with the MCA and DoLS procedures and staff demonstrated a good understanding of the MCA, DoLS, capacity and consent.

People had enough to eat and drink and enjoyed their meals. When needed, people's intake of food and drinks was monitored and recorded and prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Although staff in the home were caring and treated people with dignity and respect, there were not always enough staff to be consistently attentive to people's emotional and social wellbeing requirements. Relatives were welcome to visit as and when they wished and people were encouraged and supported to be as independent as possible.

Assessments had been completed prior to admission, to ensure people's needs could be met. People were involved in planning their care and received health care and support that was individual to their needs. Risk assessments detailed what action was required or had been carried out to remove or minimise any identified risks for people.

People living in the home, their families and staff did not currently feel able to voice their concerns or make a complaint if needed. They did not feel they were listened to, nor did they feel that appropriate responses and action were taken if concerns were raised directly with the management team.

The service was not currently being well run and communication between the management team and the staff was infrequent and ineffective. Although there were systems in place in order to ensure the quality of the service provided was monitored, the operations manager told us that these were not currently up to date and that a number of areas needed improvement.

## 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.

There were not always enough staff to support people in a timely manner and meet their needs appropriately.

Staff knew how to recognise signs of possible abuse and were confident in following the reporting procedure.

People were supported to safely take their medicines as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff were not being supported by way of relevant training, supervisions and appraisals to deliver care effectively.

People's consent was sought and nobody was being unlawfully deprived of their liberty.

People had sufficient amounts to eat and drink in the home and prompt action and timely referrals were made to relevant healthcare professionals when any needs or concerns were identified.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Staff were caring and treated people with dignity and respect but there were not always enough staff to be consistently attentive to people's emotional and social wellbeing requirements.

Relatives were welcome to visit as and when they wished and people were encouraged and supported to be as independent as possible.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People, their families and staff did not feel able to voice their concerns or make a complaint if needed.

Assessments were completed prior to admission, to ensure people's needs could be met and people were involved as much as possible in planning their care.

## Is the service well-led?

**Inadequate**

The service was not well led.

The service was not currently being well run and communication between the management team and the staff was infrequent and ineffective.

Systems were in place to monitor the quality of the service provided but these were not currently up to date and a number of areas needed improvement.

# Shipbourne House Limited

**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 was carried out by two inspectors on 3 March 2016 and was unannounced.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

As some people were not able to tell us in detail about their care, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During this inspection we spoke with six of the 15 people who were living in the home. We also spoke with the operations manager, the cook, two domestic staff and four care staff, including the senior. We also spoke with a member of the local authority's quality assurance team and a safeguarding officer before and after our inspection.

We looked at care records for seven people and a selection of medical and health related records.

On the day of our inspection visit we were unable to access the records for staff in respect of training, supervision, appraisals and recruitment. This was due to the absence of the registered manager and the operations manager. However, we did speak with staff about these areas. We were also only able to access a minimal selection of records that related to the management and day to day running of the service, although we did speak very briefly with the operations manager at the beginning of our visit.

Requires Improvement

# Is the service safe?

## Our findings

Staff worked hard to ensure people were kept safe. However, staff told us that there were not always enough of them to support people in a timely manner and meet their needs appropriately.

The home's lift had recently broken down on two occasions. The operations manager told us that on the first occasion it had been necessary for some people to be supported and sleep downstairs in the communal areas for two days. This was because they were unable to access their rooms on the upper floors. The operations manager also told us that nobody had needed to sleep in the downstairs communal areas on the second occasion, as the breakdown occurred early in the morning. The contingency plan on this occasion showed that one member of staff had been required to cover each floor and that empty bedrooms were used as additional communal areas on the upper floors. However, we noted that there had been occasions during this period when only two care staff had been on duty. This meant that there had been times when some areas of the home were left unattended by staff.

The registered manager had been covering night duties due to staff shortages and was subsequently not available on the day of our inspection. Staff told us that three care staff per shift was usually enough to be able to support people. However, although there were three care staff on duty during our inspection, one of these was the senior. In the absence of the manager, we saw that the senior was busy with administrative duties such as ordering medication. This meant that they were not able to be a fully active member of the care team. Staff told us that it was difficult to meet everybody's needs effectively with only two care staff. This was because some people required two staff to assist them with certain aspects of their care and the premises were occupied across three floors.

We noted that many of the call bells were not plugged in. The senior told us that the pressure mats were in place to alert staff to these people, as they did not know how to use the call bells. One person who was in bed pointed to their call bell and told us they used it when they needed anyone.

During our observations between 11am and 11.50am no staff entered one lounge, in which there were five of the people who lived in the home. We noted that some people called out when they wanted staff's attention but we could not be assured that people could ask for help as and when required if staff were not within earshot.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in Shipbourne House. One person said, "Oh definitely, I don't have any worries about my safety here." Another person told us, "I know the staff are not always available but when they're not busy they are kind and help me in a nice way."

Care staff we spoke with demonstrated a good understanding of what constituted abuse and told us they followed the correct reporting procedure as and when necessary. However, a member of the domestic staff

said they had little understanding of safeguarding. They told us they wouldn't know what to do if they had any concerns about how people were being supported in the home, other than to report it to the senior or registered manager.

In the absence of the registered manager and the operations manager we were not able to access the staff recruitment files during this inspection. However, staff confirmed that appropriate recruitment procedures were followed to make sure that new staff were safe to work with people who lived in the home. We were told that all staff were checked for suitability with the Disclosure and Barring Service and references were obtained before they started working in the home.

Individual risk assessments had been completed in respect of people's everyday lives, such as eating and drinking, protection from pressure ulcers, falls and mobility. Where risks to people's safety had been identified, we saw that these were recorded on an individual basis. There was guidance for staff that showed how to support people safely and effectively. Staff had easy access to these documents and we saw that they were reviewed and updated on a regular basis.

For example, one person had been losing weight and was now being monitored closely. This person's weight was being checked weekly, food supplements were being used and extra calorific drinks were being encouraged.

One person's Malnutrition Universal Screening Tool (MUST) score and 'Waterlow' rating showed a high risk in respect of pressure areas. We saw that this person had a chart that was being completed regularly to show when they had been repositioned. They also had padded air cushions for their chair and an inflated splint on their foot, due to a pressure area on their heel.

Medicines were managed and administered safely in the home and people received their medicines as prescribed. We observed the senior giving people their lunchtime medicines and noted that this was done in a professional, caring and engaging way.

We saw that people's medicines were appropriately stored in a trolley that was kept locked when not in use. People's records, including the medicine administration records (MAR), were clear, up to date and completed appropriately.

The records we looked at, together with a discussion with the senior also confirmed that people had regular reviews of their medicines. This ensured they remained appropriate for their clinical needs.

Requires Improvement

# Is the service effective?

## Our findings

The staff we spoke with were experienced and knowledgeable in their work and new members of staff were required to complete an induction. However, some training was out of date and staff did not currently feel supported by the management team.

One member of staff told us that although some training was overdue, this was in the process of being addressed. This was because the operations manager had recently purchased additional credits to reactivate their training system.

One member of staff told us that they felt the training was, "not bad" and that they felt fully supported by senior staff. However, they added that senior staff were minimal now since one had left, who they said was, "very good" and another one was currently off sick. This member of staff also said the people living in the home were not adversely affected at this time. However, they added that people were undoubtedly aware of the lack of morale within the staff team.

Another member of staff had not received any training for moving and handling since starting work in the home. However, they told us that they had significant experience in care work and their moving and handling certificate was still in date from their previous employment.

We noted that cleaning staff had not received any training in respect of Control of Substances Hazardous to Health (COSHH) or moving and handling. These were both important factors of their day to day work and potentially put them and others at risk.

Staff told us that supervisions and appraisals by the management team had not happened for some time. Staff also said that they were currently "afraid" of raising any issues with the management team.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and senior

staff ensured the service operated in accordance with the MCA and DoLS procedures and staff demonstrated a good understanding of the MCA, DoLS, capacity and consent.

Where necessary, we saw that capacity assessments had been completed for some of the people living in the home but staff told us that nobody living in the home was currently subject to DoLS. We observed staff consistently explaining to people what they were doing and asking people's permission before undertaking any personal or care tasks. One person told us, "They are always kind and offer me the support I need when I need it." And, "They always ask if it's alright before they do anything for me."

People told us they had enough to eat and drink and said that they enjoyed their meals. One person said, "I do like my food and it's always superb here."

The chef told us that, although they had not worked in the home for very long, they had a lot of previous experience. They also told us that they understood how to cater effectively for older people. We discussed some people's need for pureed and soft diets, which we saw were served as separate items, to enable people to identify the different flavours. The chef also showed us additional supplements that were available for those people who required a fortified diet, such as double cream and thick full fat yoghurts etc.

We observed the lunch time meal and noted that people were provided with cutlery and crockery appropriate to their needs. We saw that people were relaxed and were enjoying their meals in an unhurried fashion. Staff sat with some people, engaging in conversation and also encouraging people or supporting them to eat, if needed. We heard one member of staff ask, "Would you like some help with that?" to which the person replied, "Oh would you, yes please." This member of staff waited for the person to answer before acting, which ensured the person's dignity and independence was not compromised.

We noted that, when needed, people's intake of food and drink was monitored and recorded, showing clear measures of the amounts people had actually eaten, drank, or refused. This information was also audited by care staff. This ensured that prompt action was taken when people were not eating or drinking sufficient amounts, to help ensure they stayed well.

For one person who had been losing weight, we saw their records were completed properly and were up to date. We noted that this person needed to be encouraged frequently with food and drinks and that food supplements and high calorific drinks were also being offered. Staff recorded what did and did not work with this person and throughout this visit we saw and heard staff trying to encourage them to eat and drink. On many occasions the person refused but staff would return later and try again, with a good level of success.

Information in people's care records showed that prompt referrals were made to healthcare specialists when any concerns were identified. For example, the dietician and speech and language team, if there were concerns about people's weights and nutritional intake or if people had any difficulties with swallowing.

People's general health and wellbeing was also reviewed on a daily basis and care records were kept up to date regarding their healthcare needs. We noted that people were able to access relevant healthcare professionals as needed, such as the GP, district nurse, dentist, optician, chiropodist and audiologist.

Observations and information in the care records showed that staff worked in accordance with guidance provided by external professionals. This ensured that people continued to be supported and cared for effectively.

Requires Improvement

# Is the service caring?

## Our findings

Although staff in the home were caring and treated people with dignity and respect, there were not always enough staff to be consistently attentive to people's emotional and social wellbeing requirements.

We noted that some people had long finger nails that looked dirty and some had nail polish that had worn away in places. Staff and people living in the home told us that nail care had been a task that was completed by the activities person but that care staff had not had time to do this since the activities person had left the service. However, we did see that people were dressed well and in appropriately coordinated clothes. One staff member explained how they helped one particular person to choose their clothes as they knew they liked to look colour coordinated.

All the people we spoke with told us the staff were kind and caring. At 9.30am we noted that all except one person was washed, dressed and downstairs. People told us they were happy with this and said they were never made to get up or go to bed when they didn't want to. The people we spoke with also told us that staff always helped them when they were ready to get up.

The person who remained in bed said they were happy to be there and explained that they were recovering from a hip operation. This person told us, "The staff look after me the way I want and not the other way around. I like my own company and peace and quiet." This person told us they were quite content to be alone in their room and did not wish for their television to be on.

Other people we spoke with told us they were supported by a caring team with all staff treating them in a manner they would expect. One person added, "I'm sure we get on their wick sometimes but they are always very kind and do anything for you."

Throughout the day we observed staff interacting with people in a courteous and respectful manner and staff gave the impression that nothing was too much trouble for them. For example, we saw the senior stop an administrative task they were dealing with and patiently waited, in case assistance was needed by a person who wanted to mobilise independently. A lot of encouragement and reassurance was given to this person and we heard the senior say, "Let's help you get comfortable. Don't worry I'm here. Let me get you a drink; would you like a cup of tea while you get your breath back?"

Discussions with staff and our observations showed that they all had a good knowledge and understanding of each person. It was evident from the information we looked at in people's care records that people living in the home and, where appropriate, their families had been involved as much as possible in planning their own care. All the care records we looked at reflected people's personal histories and preferences, which meant that staff would know how to support them with their preferred lifestyles.

Where possible, people had regular contact with family members or friends. If people did not have any family, we noted that they would be supported to access an independent advocate if they wished.

People were also encouraged and supported to be as independent as possible. For example, by being provided with assistive equipment for mobilising or eating and drinking, being able to undertake personal hygiene tasks for themselves and choosing where they wished to spend their time within the home.

Requires Improvement

# Is the service responsive?

## Our findings

People living in the home, their families and staff did not currently feel able to voice their concerns or make a complaint if needed. They did not feel they were listened to, nor did they feel that appropriate responses and action were taken if concerns were raised directly with the management team.

Staff told us that some relatives had discussed concerns with the staff but did not want to raise them with the registered manager or operations manager for fear of repercussions for their family member by way of being given notice to leave the home.

One relative told us, "The care staff are all wonderful and I have no qualms about raising any issues with them directly. I wouldn't want [relative] to live anywhere else. [Relative] is happy and settled here and I know [relative] is well cared for. Things aren't good here at the moment though and the staff morale is through the floor. Nobody really knows what's happening with the home or the managers but things have really taken a nose-dive recently, which is a real shame because this had always been an excellent home."

These concerns constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to reduced staffing levels, people did not always receive the level of social stimulation and interaction they required. For example, during one of our observations in the lounge on the morning of this inspection, three people were asleep, one was reading the paper, one was watching the television and three other people were just sitting. Drinks had been provided and were placed on tables by each person. Newspapers were available for people and some people had teddy bears to look at but there was limited conversations and minimal stimulation. Earlier in the day a person had arrived at the home to provide some music therapy, which people enjoyed. However, when that finished at approximately 10.30am no further social interaction was provided until staff arrived to assist people to the dining room for lunch at 12 noon.

One person told us, "We have lost [Name], the activities person, who would spend time with us. Now we do nothing but watch television all day. We really miss her." Three people told us they liked doing knitting, reading, art work and going out but that this did not happen anymore. On speaking with staff we were told that this activities person had been really good in motivating people to do activities. However, this post had not been filled since the person had left three months ago.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we observed that staff were constantly busy, we noted that they responded to people's needs as quickly as possible but in a caring and unhurried fashion. This helped ensure people remained safe, relaxed and comfortable.

Assessments had been completed prior to admission, to ensure people's needs could be met. People were

involved in planning their care and received care and support that was individual to their needs. Risk assessments detailed what action was required or had been carried out to remove or minimise any identified risks for people.

The senior explained how the district nurse had recently suggested that one person had periods of bed-rest during the day to reduce the risk of them developing pressure sores. However, the staff provided a very good and justifiable reason for why it was not appropriate for this person. Subsequently, inflatable arm and leg protectors had been purchased to mitigate the risks. This assured us that staff knew this person well and were confident in discussing the best way to support people with the relevant healthcare professionals.

We spent time looking at people's care records on the computerised system used by the home. Each staff member had access to the care plans and added daily notes throughout the shift. We looked in detail at three people's care records and a sample of a further four. We saw these contained an initial assessment of needs and mental capacity assessments had been completed for those people whose capacity was in question. We also saw other information that was recorded and stored on this system. For example, potential and identified risks, people's moods and behaviours, dementia, health, activities and advanced care plans.

The senior gave us a demonstration on how the computerised care recording system would highlight when a care plan needed a review. If a score moved the person to another level of risk then a review would be held and the relevant records updated. The records we looked through were very comprehensive and easy to read, particularly for any new staff member needing to know the individual needs of each person.

Inadequate

# Is the service well-led?

## Our findings

The service was not currently being well run and communication between the management team and the staff was infrequent and ineffective. All the staff said that morale was very low at the present time, although they all tried very hard not to let this be known by the people living in the home.

Staff told us that the operations manager currently spent very little time in the home and, due to staff shortages, the registered manager had been covering night duties. This meant that the day to day running of the service was frequently the responsibility of the staff and seniors. On the day of this inspection the registered manager was unavailable, due to having just completed a night shift. The operations manager attended the home for approximately one hour upon our arrival but explained they had business outside of Shipbourne House that required their attention for the day. The operations manager did explain some of the issues the home had been experiencing, such as the loss of some good staff.

Two members of staff told us that they were very unhappy at the present time and although they had loved their job they no longer enjoyed coming to work. They said the atmosphere in the home was bad, that money was not being spent on the home and that they felt devalued.

Three members of staff told us they had recently been shouted at by the operations manager and that this was becoming a common occurrence, with other staff having been shouted at too.

Staff said they felt intimidated and unable to talk with the managers about the home. They said they worked well as a team and tried to do the best they could but that the managers had lost interest in the home. Staff told us that they were not being made aware of what was happening with the home and that a minimal amount of money was being spent on staffing and maintenance.

As a result, staff told us that various equipment such as the lift, carpet cleaner and dishwasher had recently broken down. Although the lift had recently undergone a full repair, some other items were not being replaced but simply 'patched up' so that they had become unreliable. A service engineer was attempting to repair the dishwasher during this inspection but explained that they didn't have the relevant part to complete the job that day. This person also went on to say that, as the dishwasher was a domestic model, it was not really up to the commercial level of work it was undertaking. Therefore, they said, it would probably continue to breakdown on a regular basis.

Due to the absence of the registered manager and operations manager, we were unable to access some of the records that related to the overall management of the service. There were systems in place in order to ensure the quality of the service provided was monitored. However, the operations manager told us that these were not currently up to date and that a number of areas needed improvement.

This told us that the service was not currently being well run and that people could not be assured that their needs would be consistently met appropriately.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People who use services were not protected against the risks associated with not being able to access the local community or receiving appropriate social stimulation to meet their personal preferences. Regulation 10(1)(2)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>People who use services and others were not protected against the risks associated with being unable to openly raise concerns, be listened to and have their concerns responded to appropriately. Regulation 16(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People who use services and others were not protected against the risks associated with a lack of monitoring of the service and communication with the management team that was infrequent and ineffective. Regulation 17(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People who use services and others were not |

protected against the risks associated with insufficient staffing levels. Regulation 18(1)

People who use services and others were not protected against the risks associated with staff who were not receiving adequate training, support or supervisions. Regulation 18(2)(a)