Sheldon House Ltd

Sheldon House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 28 August 2018.

Sheldon House is a care home without nursing for up to 30 people. On the day of our inspection there were 25 people living at the service. It specialises in care for older people who are living with dementia or who experience other enduring mental illness.

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.

There was not 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. The provider was in the process of interviewing for a new manager who would register with the Commission.

At the last inspection on 27 June 2017, the service was rated Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated good:

We received information of concern prior to our visit. This included care plans and risk assessments not being updated, incident forms not completed, poor leadership, care staff not being able to access information about people and GP's not being contacted about people's health concerns.

However, at this inspection we found these concerns unsubstantiated.

We met and spoke with most of the people living in the service during our visit. However, some people were not able to fully verbalise their views, so staff used other methods of communication, for example pictures. Others could tell us about the care and support they received. Due to people's needs we spent time observing people with the staff supporting them.

People remained safe at Sheldon House. People who were able to told us they felt safe living there. One person said; "Yes I do (feel safe), I have never felt so relaxed as being here. I was alone before." A relative said; "Yes, I do. I think it's the best one she's (their relative) been in, she's been in lots of homes. She's more like herself now."

People received their medicines safely by staff that had received regular updated training. People were protected by safe recruitment procedures. This helped to ensure staff employed were suitable to work with vulnerable people. People, relatives and the staff team confirmed there were sufficient number of staff to help keep people safe. Staff said they were able to meet people's needs and support them when needed.

People's risks were assessed, monitored and managed by staff to help ensure they remained safe. Risk assessments were completed to enable people to retain as much independence as possible.

People continued to receive care from a staff team that had the skills and knowledge required to effectively support them. Staff had completed safeguarding training. Staff without formal care qualifications completed the Care Certificate (a nationally recognised training course for staff new to care). The Care Certificate training looked at and discussed the Equality and Diversity and Human Rights policy of the company. One staff member said; "I love the atmosphere here and staff morale is good."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's wishes for their end of life were clearly documented. People's healthcare needs were monitored by the staff and people had access to a variety of healthcare professionals.

People's care and support was based on legislation and best practice guidelines, helping to ensure the best outcomes for people. People's legal rights were upheld and consent to care was sought. Care plans were person centred and held full details on how people's needs were to be met, taking into account people's preferences and wishes. Information held included people's previous history and any cultural, religious and spiritual needs.

People were observed to be treated with kindness and compassion by the staff who valued them. The staff, some who had worked at the service for a number of years, had built strong relationships with people. All staff demonstrated kindness for people through their conversations and interactions. Staff respected people's privacy. People or their representatives, were involved in decisions about the care and support people received.

The service remained responsive to people's individual needs and provided personalised care and support. People's equality and diversity was respected and people were supported in the way they wanted to be. People who required assistance with their communication needs had these individually assessed and met. People were able to make choices about their day to day lives. The provider had a complaints policy in place and records showed all complaints had been fully investigated and responded to.

The service continued to be well led. People lived in a service where the provider's values and vision were embedded into the service, staff and culture. People, relatives and staff said the providers were approachable.

People lived in a service which had been designed and adapted to meet their needs. The provider monitored the service to help ensure its ongoing quality and safety. The provider's governance framework, helped monitor the management and leadership of the service. The provider listened to feedback and reflected on how the service could be further improved. The provider had monitoring systems which enabled them to identify good practices and areas of 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? This service remains Good	**Good**
Is the service effective? This service remains Good	**Good**
Is the service caring? This service remains Good	**Good**
Is the service responsive? This service remains Good	**Good**
Is the service well-led? This service remains Good	**Good**

Sheldon House 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 checked 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.

The inspection was undertaken by two adult social care inspectors and an expert-by-experience on 28 August 2018 and was unannounced. An expert by- experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at other information we held about the service such as notifications and previous reports. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At our last inspection of the service in August 2017 we did not identify any concerns with the care provided to people.

During the inspection we met all the people who lived at the service and spoke with 10 people in detail about their care. Some people living at the service were living with dementia which meant they had limited ability to communicate and tell us about their experience of being supported by the staff team. Therefore staff used other methods of communication, for example by providing visual prompts. Others were able to tell us about the care and support they received. As some people were not able to comment specifically about their care experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living in the service.

We also looked around the premises. We spoke to the provider, seven staff and three relatives. We looked at records relating to individual's care and the running of the home. These included four care and support plans and records relating to medicine administration. We also looked at the quality monitoring of the service.

Good

Is the service safe?

Our findings

The staff team continued to provide safe care to people. People able to say, told us they felt safe with the staff who supported them. Some people who lived in the service were not all able to fully express themselves due to living with dementia. People were observed to be comfortable and relaxed with the staff who supported them. One person said; "Yes I do (feel safe), I never felt so relaxed as being here. I was alone before."

People had sufficient numbers of staff around to help keep them safe and to help ensure people's needs were met. Staff were recruited safely and checks carried out with the disclosure and barring service (DBS) ensured they were suitable to work with vulnerable adults. The provider was in the process recruiting additional staff to cover any vacancies. We observed staff meeting people's needs, supporting them, and spending time socialising with them.

People continued to be protected from abuse because staff knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff were confident the provider and senior staff would act, but also knew where to access the contact details for the local authority safeguarding team should they have to make an alert directly.

People did not face discrimination or harassment. People's individual equality and diversity was respected because staff had completed training and put their learning into practice. Staff completed the Care Certificate (a nationally recognised qualification for staff new to care) and this covered Equality and Diversity and Human Rights training as part of this ongoing training. People had detailed care records in place to ensure staff knew how they wanted to be supported.

People continued to receive their medicines safely from staff who had completed medication training. Systems were in place to audit medicines practices and records were kept showing when medicines had been administered. People with prescribed medicines to be taken 'when required' (PRN), such as paracetamol had records in place to provide information to guide staff in their appropriate administration.

People identified as being at risk had up to date risk assessments in place and people, or their relatives, had been involved in writing them. Risk assessments identified those at risk of falls or at risk of skin damage. They showed staff how they could support people to move around the service safely and how to protect people's skin, for example. There was clear information on the level of risk and any action needed to keep people safe. Staff were knowledgeable about the care needs of people including their risks and knew when people required extra support, for example if people became confused due to their dementia. This helped to ensure people were safe.

People's accidents and incidents were documented. People, when needed, had been referred to appropriate healthcare professionals for advice and support when there had been changes or deterioration in their health care needs.

People lived in an environment which the provider continued to assess to ensure it was safe and secure. The fire system was checked including weekly fire tests and people had personal evacuation procedures in place (PEEPs). People were protected from the spread of infections. Staff understood what action to take in order to minimise the risk of cross infection, such as the use of gloves and aprons and good hand hygiene to protect people.

The provider worked hard to learn from mistakes and ensure people were safe. The registered manager and registered provider had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Good

Is the service effective?

Our findings

The service continued to provide effective care and support to people. Staff were competent in their roles and had a very good knowledge of the individuals they supported, which meant they could effectively meet their needs.

People were supported by staff who had received training to meet their needs effectively. The provider had ensured staff undertook training the provider had deemed as 'mandatory'. This included dementia care and fire safety. New staff confirmed they'd competed the Care Certificate that covered Equality and Diversity and Human Rights training. Staff completed an induction which also introduced them to the provider's ethos, policies and procedures. Staff were supported and received regular supervision and team meetings were held. This kept them up to date with current good practice models and guidance for caring for people with a learning disability. One staff said; "Best home I have worked in for training and support."

People had access to external healthcare professionals to ensure their ongoing health and wellbeing. People's care records held details on the professionals involved in their care. For example, GPs. People's health continued to be monitored to help ensure they were seen by relevant healthcare professionals to meet their specific needs as required. For example, the district nurse team visited people to change dressings. Senior staff assisted the district nurse team to enable them to communicate any treatment back to the staff team. This helped the staff and people receiving treatment receive the advice and support needed to maintain people's health and what treatment had been completed. Staff consulted with healthcare professionals when completing risk assessments and people identified as being at risk of pressure ulcers had guidelines produced to assist staff care for them effectively.

People continued to be supported to eat a nutritious diet and were encouraged to drink enough to keep them hydrated. People were either verbally informed or staff used pictures and menus which were displayed to enable people to make a choice each day. People identified at risk of future health problems through weight loss or choking had been referred to appropriate health care professionals. For example, speech and language therapists. The advice sought was clearly recorded and staff supported people with appropriate food choices. If there were any concerns about a person's hydration or nutrition needs, people had food and fluid charts completed and meals were provided in accordance with people's needs and wishes. Care records recorded what food people disliked or enjoyed.

People were encouraged to remain healthy, for example people did activities that helped maintain a healthier lifestyle. For example, chair exercise to maintain their mobility.

People's care files showed how each person could communicate and how staff could effectively support individuals. Staff demonstrated they knew how people communicated and encouraged choice whenever possible in their everyday lives. This showed they were looking at how the Accessible Information Standard would benefit the service and the people who lived in it. The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People's legal rights were upheld. Consent to care was sought in line with guidance and legislation. The provider had understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). People's care plans recorded their mental capacity had been assessed when required, and that DoLS applications to the supervisory body had been made when necessary. Staff had received training in respect of the legislative frameworks and had a good understanding. This showed the provider was following the legislation to make sure people's legal rights were protected.

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 so that they can 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).

People were not always able to give their verbal consent to care, however staff were heard to verbally ask people for their consent prior to supporting them, for example before assisting them with their personal care needs. Staff waited until people had responded using body language, for example, either by smiling or going with the staff member to their rooms.

People lived in a service which had been designed and adapted to meet their needs. Specialist equipment in bathrooms meant people could access baths more easily. People lived in a service that continued to be maintained, and planned updates to the environment were recorded.

Good

Is the service caring?

Our findings

People continued to be provided with a caring service. People, when asked if they felt well cared for, commented; "Yes they are as good as gold" and "Oh yes, they treat me well" and "Yes, I can't see that they can do more than they do." A relative said; "Yes, I do, I do actually" and "This is the best one (home) she's been too." Professionals also commented that people where well cared for.

People continued to be supported by staff who were both caring and kind and we observed staff treated people with patience, kindness and understanding. People were seen chatting with staff and the conversations were positive and we heard and saw plenty of laughter and smiles. Staff were attentive to people's needs and understood when people needed reassurance, praise or guidance. People, at times became confused or anxious. The staff then spent time providing reassurance to people, listening and answering people even when the questions were repetitive. One staff member remained in the main lounge area at all times to provide reassurance for people.

People told us their privacy and dignity was maintained and respected always. Staff were observed to knock on people's doors and ask them if they would like to be supported. We saw people were able to make choices about how they spent their time and were able to spend time in their rooms if they wished. Staff told us how they maintained people's privacy and dignity, in particular when assisting people with personal care. Staff said they felt it was important people were supported to retain their dignity and independence. One staff member said; "We try and give people the best care we can."

The staff and management team understood the importance of confidentiality. People's records were kept securely and only shared with others as was necessary. This was in line with the new General Data Protection Regulations (GDPR). Staff spoke to us about how people would be treated and cared for equally regardless of their sexual orientation, culture or religion. The provider and staff said everyone would be treated as individuals, according to their needs.

People were supported to express their views whenever possible and be involved in any decisions about the care and support they received. Staff were seen communicating effectively with people. This helped to ensure people were involved in any discussions and decisions as much as possible. Interactions we observed whilst staff supported people were good. Staff understood if people could verbally respond or if they were upset, also using body language.

People or their representatives were involved in decisions about their care. People had their needs reviewed on an annual basis or more often if their care needs changed. Family members were seen to have been involved with their relatives' care.

Staff showed concern for people's wellbeing. People with deteriorating health were observed to be well cared for by staff with kindness and compassion while maintaining people's dignity. The care people received was clearly documented and detailed. People now confined to bed due to their deteriorating health, were seen to comfortable and received continued care and attention from the staff.

The values of the organisation ensured the staff team demonstrated genuine care and affection for people. This was evidenced through our conversations with the staff team. People received their care from a regular staff team some who had worked at the service for many years. This consistency helped meet people's needs and gave staff a better understanding of people's communication needs. It supported relationships to be developed with people so they felt they mattered.

Good

Is the service responsive?

Our findings

The service continued to be responsive. People were supported by a staff team who were responsive to their individual needs. People had a pre-admission assessment completed before they were admitted to the service. The provider confirmed this helped to enable them to determine if they were able to meet and respond to people's individual needs.

People's care plans were person-centred and held detailed information on how each person wanted their needs to be met in line with their wishes and preferences. People's records also held information on people's social and medical history, as well as any cultural, religious and spiritual needs. Staff monitored and responded to changes in people's needs. For example, any decreases in people's general health or dementia were identified and specialist advice was sought. Staff said they encouraged people to make choices as much as they were able to. Staff said some people were given verbal choices while others were shown visual clues to make choices from.

If people and staff had protected characteristics under the Equality Act, the provider assured us their own policies reflected this to ensure people were treated equally and fairly.

People received individual personalised care. People's communication needs were effectively assessed and met and staff told us how they adapted their approach to help ensure people received individualised support. The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was provided to people in a format suitable to meet their individual needs. For example, picture menus and a list of activities planned were displayed for people to see and read what was going on

The provider had a complaints procedure displayed in the service for people and visitors to access. Where complaints had been made, records showed they had been fully investigated and responded to. The provider had taken action to make sure changes were made if the investigations highlighted shortfalls in the service. People had advocates, for example family members, available to them to help ensure people who were unable to effectively communicate, had their voices heard and this information could be provided in a format of people's choice.

People's end of life wishes were documented to inform staff how each person wanted to be cared for at the end of their life. This would help ensure people's wishes were respected. Professionals said people had their healthcare concerns addressed and attended to as the provider and staff were always willing to seek advice and support.

People took part in a range of activities. Some external entertainers visited the service and staff also arranged everyday activities for people. People said of the activities provided; "We have singers and the art lady" and "We do cooking and we all help" and "I like the singer."

Good

Is the service well-led?

Our findings

The service remains well-led. There was not currently a registered manager in post. However, a registered manager from Sheldon House's sister home and the provider were currently overseeing the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People lived in a service whereby the provider's caring values were embedded into the leadership, culture and staff practice. People and staff all spoke very highly of the provider. Comments included; "If I ever have any queries, I just talk to the staff, they're so easy to talk to" and "I would go to the nursing office and whoever is in charge. I have got to know a lot of them now." Staff said; "I think the owners recruit a good calibre of staff" and "Our ideas are taken on board and we feel listened to."

The provider was open and transparent and was very committed to the service and the staff but mostly the people who lived there. They told us how recruitment was an essential part of maintaining the culture of the service. The provider was in the process of interviewing suitable candidates for the manager post and said they wanted to be sure they took on the best person for the job. People benefited from a provider who worked with external agencies in an open and transparent way and there were positive relationships fostered.

Staff were motivated and hardworking. They shared the philosophy of the management team. Shift handovers, supervision, appraisals and meetings were seen as an opportunity to look at current practice. Staff spoke positively about working with the provider and the service.

Staff spoke fondly of the people they cared for and stated they were happy working for the provider but mostly with the people they supported. Management monitored the culture, quality and safety of the service by visiting to speak with people and staff to make sure they were happy. Staff said; "We are like one big family" and "We treat people like our own family." That was evident throughout our visit.

People lived in a service which was continuously and positively adapting to changes in practice and legislation. The provider was fully aware of and had implemented the Care Quality Commission (CQC) changes to the Key Lines of Enquiry (KLOE). They had also looked at how the Accessible Information Standard would benefit the service and the people who lived in it. This was to ensure the service fully met people's information and communication needs, in line with the Health and Social Care Act 2012.

The provider's governance framework helped monitor the management and leadership of the service, as well as the ongoing quality and safety of the care people were receiving. For example, systems and process were in place such as, accidents and incidents, environmental, care planning and nutrition audits. These helped to promptly highlight when improvements were required.