

Sherborne Court Neurological Centre Limited

# Sherborne Court Neurological Centre

## Inspection report

Sherborne Road  
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Cheshire  
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Tel: 01270531080

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13 February 2018

19 February 2018

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection was unannounced and took place on 12, 13 and 19 February 2018.

We had previously inspected the home on 14 March 2016, when it was under a different provider and was called Huntercombe Neurodisability Centre, Crewe. When the new provider took over the home in October 2017, the registered manager and other staff remained the same. This was our first inspection since the location had been re-registered with us.

Sherborne Court Neurological Centre 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. The service accommodates up to 40 people in one purpose built building. There were 33 people receiving a service on the day of the inspection.

There was a registered manager. 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.

We identified four breaches of the relevant legislation, in respect of safeguarding, management of risk, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

We found that systems in place did not effectively ensure that people were always safeguarded from potential abuse and harm. We asked the registered provider to raise a safeguarding referral with the local authority during the inspection. Further safeguarding training for staff was subsequently arranged.

Risk assessments were generally undertaken and action identified to prevent further occurrences. However we found that this system was not sufficiently robust because risks associated with one person's care had not been fully assessed and documented to help staff know how to mitigate any future risk.

Nursing staff numbers had been reduced for a trial period and staff told us that this had impacted on their workloads. We were concerned that due to the complex needs of people that staff were not sufficiently deployed. The provider and registered manager told us that they were reviewing the staffing levels.

Overall we found that medicines were managed safely. There were some minor short falls relating to the recording around medicines.

The home was clean and well maintained. Staff had received training in fire awareness as part of their induction. Fire drills and simulated evacuations had been carried out occasionally but there were no records

to demonstrate that night staff had not been included. We raised this with the registered manager.

People were supported to have sufficient to eat and drink. We received positive feedback about the food and drink available. We saw that where people needed support, this was provided in a sensitive and unrushed manner.

New staff to the service completed an induction. The new provider was introducing a new e-learning system for all mandatory training. The system was not yet fully up and running, some staff were awaiting access to the system. Face to face training had been carried out in other subjects. Staff received supervision and appraisals, although these were behind. Action was being taken to improve this.

Overall, we found that where possible people were supported to make their own decisions. Staff sought consent from people before they provided any support. Where people did not have the capacity to make their own decisions, staff followed the Mental Capacity Act 2005 (MCA)

The premises were suitable to meet the care and support needs of the people living there. The new provider had commenced some renovation of the building. New flooring had been laid in the communal areas and re-decoration was underway.

People's personal information was kept more securely. We saw evidence that the management team were monitoring privacy and confidentiality issues.

Staff were kind and caring in their approach. People told us that they were treated with dignity and their privacy was respected. Staff were knowledgeable about people likes and preferences. We saw that staff ensured that people's communication needs were taken into account.

People received person centred care and we found examples of good outcomes for people.

Care plans and records were in need of improvement. We found that relevant information had not always been recorded and updated. Out of date information was found in people's bedrooms. There were occasional gaps in records completed by staff.

People were supported to follow their interests and take part in activities. The home employed an activities coordinator, as well as a music therapist and two therapy assistants who supported people with a range of activities.

There were audit systems in place to monitor the quality of the service. The new provider had introduced a schedule of audits but these were not yet fully embedded. Although some systems were in place, they had not been used effectively because they had not identified issues found at this inspection.

People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements.

## 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.

Local safeguarding procedures had not always been followed.

The management of risk had not always been assessed safely.

There had been a reduction of nursing staff which impacted on workload and the provider was addressing this.

There were some minor shortfalls regarding medicines management.

The service was clean and well maintained, some refurbishment was underway.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

People were supported to have sufficient to eat and drink and were generally positive about the food and drink available.

Staff received appropriate induction and training. Aspects of training were being developed further.

Staff supervision and appraisals had fallen behind but this was being addressed.

Staff followed the MCA, however we found that best interest decision needed to be kept under review.

### Is the service caring?

**Good** ●

The service was caring.

Staff were kind and caring in their approach.

People's privacy and dignity were respected.

People were encouraged to express their views regarding the service and were involved in decision-making about their care.

Staff promoted and enabled people to be as independent as they wanted to be.

### **Is the service responsive?**

The service was not consistently responsive.

There were gaps in the recording of people's care needs.

Care was provided in a person centred way and there were examples of good outcomes of people.

People were supported to follow their interests and take part in activities.

There was a complaints policy and procedure in place which was followed.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not consistently well-led.

The service had been through a period of transition whilst a new provider had taken over.

There were quality assurance systems in place but these were not effective enough to highlight the concerns noted on this inspection.

People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements.

**Requires Improvement** ●

# Sherborne Court Neurological Centre

## **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 12, 13 and 19 February 2018 and was unannounced. The inspection was carried out by one adult social care inspector, one expert by experience and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second and third days.

Before the inspection we checked the information that we held about the service. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. The registered manager had not received a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However we gathered this information during our inspection.

We contacted the local authority before the inspection and they shared their current knowledge about the home. They had no concerns with regards to the care provision. We checked to see whether a Health Watch visit had taken place, however a recent visit had not taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with seven people who lived at the service and six relatives/visitors,

to seek their views. We spoke with 15 members of staff including, four nurses, five healthcare assistants, the registered manager, the deputy manager, the area manager, the head of housekeeping, the physiotherapist and the maintenance person. We also spoke with a visiting health professional.

We looked at the care records of six people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people and observed the lunch-time meal.

## Is the service safe?

### Our findings

We found that systems in place did not effectively ensure that people were always safeguarded from potential abuse and harm. We identified that a sequence of incidents had occurred in relation to a person living at the home. The incidents raised potential safeguarding concerns and should have been reported to the local authority under local safeguarding procedures. However they had not been referred. Whilst actual harm had not occurred and staff had taken some informal action to protect people, we found that this was not sufficiently robust. The registered manager was not aware of the most recent incident and incident forms had not been completed by staff for all of the incidents. We raised this with the registered manager who agreed that the matter should have been reported as a safeguarding concern and made a referral straight away.

We also found that risks associated with this person's care had not been fully assessed and documented to help staff know how to mitigate any future risk. The person was relatively new to the service and we reviewed the person's care plan. We saw that a meeting had been held to assess one area of risk, but none of the other significant risks had been assessed. In view of the potential safeguarding concerns, a risk assessment should have been undertaken to assess whether any further actions were necessary to address the risk. We were advised on the final day of the inspection that this had been completed and further action had been taken to address any potential risks.

This was a breach of Regulation 12 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to any safeguarding concerns or referrals were kept on an electronic system. The registered manager advised us that there had only been one safeguarding referral to the local authority since the new provider had taken over. She was able to inform us verbally of the outcome of this safeguarding issue, although we could not see that this was recorded. The registered manager told us that there was now a system in place which meant that she had to report any safeguarding concerns and their outcome to the registered provider on a monthly basis. The deputy manager told us that they had recently developed a new safeguarding file for staff, which included appropriate procedures to follow. Staff had undertaken safeguarding training although one member of staff told us that they had not completed this for "some time." On the final day of the inspection the registered manager told us that she had organised for staff to undertake refresher safeguarding training as a matter of priority.

Risk assessments had been undertaken in a number of areas. We saw that aspects of risk management took into account the least restrictive option and supported people to keep as much control over their lives as possible. For example following an incident, a review of the risks had been undertaken with the person and their views were taken into account. It was recorded that they were aware of the risks but would rather remain independent rather than having any preventative measures put in place.

We found that certain records including care plans and other guidance kept in people's bedrooms had not always been updated to reflect changing needs and changes to the management of risk. For example, we



found that staff did not always have current guidance about people's nutritional needs. We saw that thickener agent was used to thicken some people's drinks to reduce the risk of choking. In two cases we saw that information kept in people's bedrooms had not been updated to indicate that these people required thickened drinks. One person had a very detailed eating and drinking one sheet guide, but this had not been reviewed since 2016. Whilst staff spoken with were clear about people's nutritional requirements, agency staff were used within this service and information and some records had not been kept up to date with people's current care and health needs.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

Accidents and incidents were recorded and the registered manager undertook a monthly analysis to identify whether there were any themes or trends. We saw that action had been taken to review and mitigate further risks. For example, where a person had experienced three falls they were reviewed by a physiotherapist and their level of support had been increased. The use of appropriate equipment was also introduced in another example. Quarterly health and safety meetings were held. We saw from the latest minutes that a range of topics were discussed which included risk assessments, any accidents and incidents plus improvements made to reduce re-occurrence of accidents, infection control, training and fire amongst other issues.

We found that nursing staff were not always deployed in a way to meet people's needs. We discussed staffing levels with people, relatives and staff. They told us that since November 2017, there had been a reduction in the number of nursing staff on duty during the day, which had reduced from four to three. This meant that there was one nurse on each floor with a "floating" nurse who worked between the two. The first floor of the unit was described as the high dependency unit where a number of people had complex clinical needs. Staff told us that whilst they felt that overall there were sufficient health care staff to meet people's needs, they believed that the reduction in nursing staff had an impact on nurses' availability to undertake certain tasks. We saw that nursing staff had raised their concerns in a meeting with the management team. A relative also expressed a concern about nurse availability. We were advised that staff now found it difficult to review care plans and undertake supervisions of staff. We saw that one care plan had not been fully written for a person who had moved into the home five weeks prior.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager told us staffing levels were based on people's assessed need and funding agreed by placing authorities. Arrangements were being made for people to have their funding reviewed by commissioners to ensure that these were correct. The registered manager told us that the staffing levels were currently under review. The reduction in nursing was for a trial period. She advised that the deputy and herself were also available to support where necessary. The nurses had been asked to record any specific issues as a result of the changes. The registered manager told us that the dependency levels of people had increased and she had used a dependency tool with staff to provide a guide on the staffing hours required. This indicated that extra nursing hours were required to meet current dependency levels. She advised that this is currently being considered with the provider.

Agency staff had been used to cover where there were staff shortages. These are staff who are employed by a separate organisation which provides staff to any service which requires them. We saw from the rotas that there had been a high usage of agency staff more recently. The registered manager explained to us that agency staff were used when necessary to ensure people's needs were met as safely as possible. They had tried to work with particular agencies to ensure that the staff used were as consistent as possible.

We were told that where agency staff were used they undertook an initial induction and the service received

a profile from the agency to confirm their skills and training. However, we could not evidence that profiles and completed inductions were in place for all agency staff used. We discussed this with the registered manager who subsequently changed the process to ensure that these were always undertaken and recorded correctly.

There was a recruitment campaign underway and the registered manager told us that six new members of staff were currently in the recruitment pipeline. A new nurse was currently undertaking an induction and there were further interviews planned that week.

We found that medicines were managed safely. Safe medicines management processes were in place and people received their medicines as prescribed. Medicines were stored securely and at the correct temperature. Accurate records were maintained of medicines administered, including controlled medicines. Systems were in place to make sure medicines were ordered, stored and disposed of safely.

However, we identified some minor shortfalls with aspects of medicines management. We noted that medication instructions had been handwritten on one of the MARs and had not been signed or countersigned to confirm the recorded instructions were correct. Also we did not see guidelines for when some prescribed 'as required' medicines should be administered. Some people using the service were not able to verbally communicate if they needed an 'as required' medicine such as pain relief. Guidelines for nurses as to how people would communicate non-verbally their need for an 'as required' medication were required consistently. People who had been prescribed topical medicines (creams/gels). We saw that there were charts in place for staff to sign when they had applied any creams, however we found that there were some gaps in these and it was unclear whether the creams had been missed or not required. Information was not clearly recorded on the charts about when these creams should be applied. This could lead to potential confusion and treatment not being administered as prescribed. We discussed this with the registered manager who told us that action would be taken to address this.

We carried out a tour of the premises and saw that people were cared for in a clean and hygienic environment. New cleaning schedules had been introduced. Staff were wearing appropriate gloves and aprons to reduce the risk and help the prevention of infections. CQC had been informed about a concern regarding the availability of personal protective equipment (PPE) such as gloves and aprons. The registered manager informed us that stocks had run low recently due to a change of supplier. However she assured us that the home had not run out completely because extra supplies were purchased locally. She confirmed that action was being taken by the new provider to ensure that there was a sufficient budget for PPE equipment and that a backup supply would be available so that stock did not become low in future.

The service employed a maintenance person and we saw from the records that he completed various daily, weekly and monthly checks to ensure the safety of the premises. These included checks on the safety of equipment used. We saw that there were personal emergency evacuation plans (PEEPs) in place. These identified people's needs so that staff and emergency services could respond as necessary in the event of an emergency. Staff had received training as part of their induction. Fire drills and simulated evacuations had been carried out occasionally but there were no records to demonstrate that night staff had not been included. The registered manager told us that there had been a drill in August 17 during the night but this had not been recorded as such. The registered manager agreed to address this.

## Is the service effective?

### Our findings

At our last inspection under the previous provider we raised concerns that people's nutritional needs were not being met effectively. At this inspection we found that improvements had been made and people were happier with the support provided.

People were supported to have sufficient to eat and drink. People were generally positive about the food and drink available. They commented, "Meals are nice" and 'Nothing is a problem with the meals'. There were four weekly menus and people had a choice of meals, alternatives were also available. One person explained how kitchen staff met their individual requirements and purchased specific yoghurts for them. We saw that the food provision had been discussed at a recent resident's meeting. The feedback provided was positive and everyone commented that they liked the meals. One person however told us that they were unhappy with aspects of the food. The registered manager explained that there had been a recent problem with the meat quality which had been raised with the suppliers.

During the inspection we observed a lunch time meal. We saw that where people needed support, this was provided in a sensitive and unrushed manner. One person was very anxious and wanted their meal prior to the planned lunchtime. Staff were responsive to their request and brought their meal without delay. However the person did not like the meal, so staff offered an alternative which the person again wasn't keen on. Staff were caring in their approach and offered sandwiches as a further alternative.

There was a café which had been introduced within the premises, which was run by the people living at the home. The activities coordinator supported people to undertake the different roles. This provided people with the opportunity to improve their skills, as well as an opportunity for others to socialise in a café type environment.

Staff used the Malnutrition Universal screening Tool (MUST) to help monitor people's health and nutritional support needs. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. However we saw a couple of examples where the tool had not been used correctly and was therefore inaccurate. The registered manager told us that she would discuss this with staff and ensure that all staff fully understood how to use it. Overall we saw that people's weights were monitored and where necessary appropriate advice was sought.

People and their relative's told us, "They're marvellous (the staff), they look after him (relative)" and "The majority of staff are very good." New staff completed an induction which was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. An induction pack was in place and staff were signed off when they were deemed to be competent. The new provider was introducing a new e-learning system for all mandatory training. The system was not yet fully up and running, some staff were awaiting access to the system. The registered manager showed us the latest training statistics available from the previous provider which demonstrated that staff had completed training in topics such as fire safety,

infection control, Mental Capacity Act 2005, safeguarding and medication amongst others. Two members of staff had recently completed a "train the trainers" programme which enabled them to provide moving and handling training to other members of staff. Face to face training had also been undertaken in other subjects.

A number of people living at the service required support with tracheostomy care. This is when people are supported to breathe via a tube. Prior to our inspection CQC had been made aware of a concern regarding the availability of staff trained to undertake particular aspects of tracheostomy care. Further enquiries identified that there had been an occasion where for a period of time the nursing staff on duty were not signed off as competent in tracheostomy care, although they had undertaken training. The registered manager told us they usually had sufficient skilled staff cover from the physiotherapist, nursing staff and bank staff, but due to unforeseen sickness they were unable to cover on this occasion for a period of three and a half hours. A risk assessment and contingency plan was put in place at the time. We were advised that all nursing staff were undertaking the appropriate training and competency assessments to ensure that there was a larger pool of staff available to provide appropriate cover. A new member of staff was due to start at the service who had completed this training. All health care assistants were also being trained in general tracheostomy care.

The new provider had introduced new supervision and appraisal paperwork. The new process was being embedded and we found that there were some gaps in the frequency of supervision received by the staff. Staff spoken with told us that they have received supervision but some said that it had not been for a while. We saw that this had been identified within the area manager's latest monthly visit and action had been highlighted to address this.

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).

Overall, we found that where possible people were supported to make their own decisions. Staff sought consent from people before they provided any support. Where people did not have the capacity to make their own decisions, staff followed the MCA. We saw examples of MCA assessments and best interest decisions being recorded. Where a person received their medication covertly (hidden in food or drink) a mental capacity assessment and best interest decision had been carried out, however we saw that this decision had not been reviewed for a significant period of time. Good practice guidance suggests that such decisions should be reviewed on a regular basis to ensure that the decision remains in the person's best interests. We pointed this out to the registered manager who advised that the person's care plan around medication had been evaluated regularly but agreed to ensure that the best interest decision were also regularly reviewed and documented.

People were supported to maintain good health. Records maintained showed that staff sought advice from appropriate health professionals where necessary. We saw that people had access to their GP. We saw that referrals were made to other health professionals such as tissue viability nurses or dieticians where necessary. We saw for example that staff had incorporated and followed recent guidance from a specialist nurse in respect of one person.

A visiting dietician was undertaking a number of reviews during our inspection. She told us that she had made a number of recommendations regarding the support that people received with their nutritional needs. She planned to support the service with further training. It was highlighted that there appeared to have been some delays in gaining access to speech and language therapy reviews for some people, as the service's speech and language therapist was currently absent. The registered provider employed healthcare professionals within the service including a psychologist, speech therapist, and physiotherapist. The service required temporary cover for the physio therapy and SALT roles. During the inspection we were informed that appropriate cover had been arranged. The service had not been able to access these services through people's GPs.

The premises were suitable to meet the care and support needs of the people living there. The new provider had commenced some renovation of the building. New flooring had been laid in the communal areas and re-decoration was underway. People living at the home had been consulted with regarding choice of colour and furniture. A breakfast bar had been fitted which was wheelchair accessible and meant that people could sit at the breakfast bar for meals or other activities should they choose. Action was also being taken to ensure that all people had access to the garden areas. Work was due to be completed to make the paths in the garden more wheel- chair accessible. We observed that people's bedrooms were extremely personalised and many contained pictures or memorabilia that was meaningful to the individual.

## Is the service caring?

### Our findings

People and their relatives told us that they were treated with kindness, dignity and respect. Comments included "Nursing is very good and caring", "Staff are friendly" and "We can make ourselves a drink. There's always someone around. People are on first name terms with staff. Its family orientated."

During our last inspection under the previous registered provider, we were concerned that people's confidentiality had not always been maintained. At this inspection we found improvements and that people's personal information was kept more securely. We saw evidence that the management team were monitoring privacy and confidentiality issues and had used meetings to remind staff about these issues and asked staff to read their policy on confidentiality.

We observed staff interactions with people and saw that staff were kind and caring in their approach. They spoke with people in a friendly manner, were patient and gave people time to respond. For example one person appeared to be tearful and we saw a care assistant put their arms around the person's shoulders and asked quietly if they could help. Another member of staff was seen to be chatting to a person; they were sharing a joke which both found really funny. People looked comfortable and at ease within the home.

We saw that the home had received a number of thank you cards and compliments. One card received from a relative read "You made her (relative) happy and ensured she kept her dignity at all times." Visiting relative's told us that they could visit at any time and were made to feel welcome. People were supported to maintain relationships which were important to them. One person told us how they regularly enjoyed trips out with their relatives.

Staff were knowledgeable about people's needs and preferences. Each person had a member of staff who was their key worker as well as a named nurse. We saw that this role had been discussed within a resident's family meeting and further training was planned to improve the role further. Each person had a person centred plan called "All about Me" available in their room, this provided key information about their backgrounds, likes and dislikes. The plan included information on how best to talk with the person, as well as "top tips" for supporting the person. One staff member commented "We all know the residents inside out." We saw for example that one person was particularly keen on dogs and their plan stated that they enjoyed conversations about dogs. During lunchtime a member of staff was supporting this person with their meal. They noticed a dog through the window and started a conversation about this, which the person responded to positively.

Equality and Diversity was part of the provider's mandatory training requirements to ensure people were cared for without discrimination and in a way that respected their differences. We saw that staff supported people to maintain their religious and spiritual beliefs. For example one person was supported to visit a local mosque and an area within the building had been adapted into a suitable prayer room.

Staff sought accessible ways to communicate with people. For example questionnaires had been issued to people in easy to read formats. One person did not speak English and staff had arranged for a suitable

television channel to be provided. A talking map and pictures had been used to support another person to involve them in a decision about a medical intervention. The registered manager was aware of the Accessible Information Standard and advised that they were continuing to adapt their approach to meet this standard.

People were encouraged to express their views regarding the service and were involved in decision-making about their care. Care plan reviews were held and people and their relatives were included where appropriate. There were a number of people within the service who received support from independent advocates. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities.

People told us they felt their privacy and dignity was respected. They said that members of staff treated them well. We observed how staff knocked on doors and kept them closed when supporting people with personal care. One person had their bedroom door left open for the majority of the time, they told us that this was their preference and that staff respected this choice.

Staff promoted and enabled people to be as independent as they wanted to be. The service was focused on supporting people to identify and achieve goals. The registered manager told us that they had recently undertaken training and were introducing a new approach to support people to reach their potential. They had introduced Goal Attainment Scoring (GAS) which is a way to identify and measure whether people are achieving their goals. The registered manager planned to roll this out throughout the service and further staff were undertaking the training. We also saw two examples where people's mobility had improved significantly following support from the physiotherapist within the service.



## Is the service responsive?

### Our findings

We inspected the care records of six people who lived at Sherborne Court. We found that one person had been living at Sherborne Court for around five weeks, but their care file contained minimal information. There were a number of blank care plan templates waiting to be written, however only one of these had been completed for the person's elimination needs. We spoke with one member of staff who told us that they had some concerns about aspects of this person's care and that at times they were uncertain how best to respond. We found that the care records did not provide staff with sufficient guidance. We discussed the care plan with the registered manager who was unaware that the care plan documentation had not yet been completed. She assured us that this would be completed as soon as possible.

We also found there were gaps in the documentation recorded by staff. Staff were required to complete daily care records to evidence the support provided to each person. However there were occasional gaps in the care records and that charts were not always fully completed. These included charts for positional changes, personal hygiene and oral hygiene. The registered manager confirmed that one person had received appropriate oral care but that the records relating to this were inconsistent and recorded in different places.

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

The registered manager explained that record-keeping training has already been arranged and was due to take place within the next two months. The care plans were in the process of being re-written onto the new provider's documentation. Further care plans reviewed contained person centred information, such as information about people's preferences, likes and dislikes. For example one stated that a person preferred a male carer to support with personal care. Care plans were in place for topics such as, communication, mobility, mental health, nutrition, falls, personal care, medication support and skin integrity. The majority of the care plans had been evaluated monthly to ensure that they reflected people's current needs. There were some areas which needed to be improved further for example where people's care needs had changed significantly this information was written into on-going evaluations and it wasn't easy to identify the person's current level of need. We found that one person required thickened fluids to help prevent the risk of choking. This information was only recorded in an evaluation but it was difficult to identify this, as there were lots of other later entries.

As part of their assessments people were asked whether they had any specific communication needs, which was recorded. People had communication care plans which described people's communication abilities, how they preferred to communicate and what support they required from staff. Technology was also used to help people receive timely support. Call bells and sensors were used to help staff know when people required assistance. Staff also supported people to use I-pads and undertake Skype calls to communicate with others.

People and their relatives were generally positive about the care and treatment they received and told us



that staff were responsive to their needs. A relative told us, "I'm happy enough with the care implemented. I was involved with [relative's] care plan and it is reviewed regularly." Where a person had specific sensory support needs, staff ensured that appropriate equipment was purchased to support the person effectively during bath time. There were further examples where people's support was provided in a person centred way. There had been a positive outcome for a person through music therapy support, with increased social interaction.

People spoken with confirmed that staff respected their preferences. We saw for example that one person liked to have their breakfast at 5am and that another person liked to stay in bed until lunchtime, which staff respected. However one member of staff felt that there was an "institutional approach" at times, because they believed they had to ensure that people were up and had received breakfast by 10am. However staff also told us that they respected people's preferences and would not insist that people got up if they did not wish to. We saw examples during the inspection of people getting up later in the morning. We discussed this issue with the registered manager who told us that they had been working with staff to ensure that the morning medication round was completed in a timely manner and had instructed the nursing staff to ensure that all medicines were administered by 10am if possible. There were also cases where best interest decisions had been made to encourage some people to get up and ready in a morning to support their mental health needs. The registered manager was clear that their approach was person centred and would talk to the staff about their understanding around this issue.

People were supported to follow their interests and take part in activities. The home employed an activities coordinator, as well as a music therapist and two therapy assistants who supported people with a range of activities. People and relatives were very positive about the benefits of the music therapy. There was a therapy kitchen where people were supported to cook and prepare meals. The registered manager told us that staff had been trained in Namaste care, which aims to engage people living with dementia or other neurological conditions. This approach focuses on touch and sensory stimulation. People had made suggestions in resident's meetings about the types of activities that they would enjoy. We saw for example that a monthly "takeaway" night had been introduced following a suggestion.

Under the previous registered provider, people had access to a minibus. This was no longer available and people had noticed the impact of this. Staff told us that one person in particular had not been able to attend a community activity or visit their relative as often as before. The new provider assured us that they were in the process of arranging for a new minibus to be purchased.

People and relatives spoken with told us that they felt able to raise any concerns or issues. There was a complaints policy and procedure in place which was followed. The provider's complaints log evidenced that previous complaints had been fully investigated and where appropriate action taken to address concerns. The registered manager undertook a monthly audit of any complaints which identified whether they were written or verbal complaints and the progress on any action taken.

People's care records showed that they had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. The service also had links with the local End of Life Partnership to support people and staff appropriately.

## Is the service well-led?

### Our findings

There was 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 service had been through a period of transition whilst a new provider had taken over the service in October 2017. The registered manager had also transferred and told us that she felt excited about the new provider and their plans to develop the service. The registered manager was supported by a deputy and both had good knowledge of people who lived at the home. They were focused on the quality and the recruitment of staff was being prioritised as well as the organisation of staff. For example an allocation system had been introduced with senior roles.

Whilst staff told us that they felt the registered manager was approachable, some staff reported feeling unsupported and raised concerns about current pressures relating to workload. Staff meetings were held and we saw from the minutes that these enabled staff to provide feedback and share their views about the service. A daily heads of department meeting also took place to help ensure that information was shared effectively throughout the team.

There were audit systems in place to monitor the quality of the service. The new provider had introduced a schedule of audits but these were not yet fully embedded. These included audits for medicines, care planning, and infection control. We also saw evidence of regular provider visits to maintain oversight of the service. Although these systems were in place, they had not been sufficiently effective because they had not identified issues found at this inspection

This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that she felt supported by the new area manager and that they visited the home several times per month. We met with the area manager who explained that she was supporting the management team to improve and maintain standards; management training had been arranged for some staff.

People and relatives told us that they knew who the registered manager was and said she was visible around the building. They felt able to raise concerns and said that the management team were usually responsive.

People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements. We saw that residents meetings were held to discuss recent events and activities and that people were regularly asked to provide feedback about various aspects of the service. The registered manager told us that people living at the service were encouraged to chair the meeting with

support for the psychologist, which demonstrated an inclusive approach.

Surveys had been carried out with people and relatives to gather their feedback about the service. The new provider had also held drop in sessions, to enable relatives to discuss any issues about the current service. We saw that some of the actions identified as a result of these meetings had already been actioned or were in progress. This included the purchase of a new vehicle, wheelchair access to the garden and redecoration of the communal areas.

The service worked closely with other agencies such as GPs, the clinical commissioning group and the local authority to ensure as far as possible that care was effective and responsive in meeting the needs and expectations of people.

Our records demonstrated that the registered manager notified CQC of significant events appropriately, as legally required to do so

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 12 HSCA RA Regulations 2014 Safe care and treatment  |
| Diagnostic and screening procedures                            | Risk assessments had not always been completed for people using the service.  |
| Treatment of disease, disorder or injury                       |   |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment   |
| Diagnostic and screening procedures                            | Systems and processes to investigate any allegation or evidence of abuse had not always been operated effectively.  |
| Treatment of disease, disorder or injury                       |   |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance  |
| Diagnostic and screening procedures                            | Complete and contemporaneous records in respect of each service users had not always been kept. Systems and processes to assess, monitor and improve the quality of the service were not effective. |
| Treatment of disease, disorder or injury                       |   |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing   |
| Diagnostic and screening procedures                            | Sufficient numbers of suitably qualified, competent, skilled and experienced people had not always been deployed.   |
| Treatment of disease, disorder or injury                       |   |

