Shelbourne Senior Living Limited

The Shelbourne at Sway

Inspection report

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Sway
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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

Overall summary

The Shelbourne is registered to provide accommodation and personal care for up to 68 older people some of who may be living with dementia This service did not provide nursing care. On the day of our inspection 54 people were living at the home.

Accommodation at the home is provided over three floors, which can be accessed using stairs or passenger lifts. There are large garden and patio areas which provide a secure private leisure area for people living at the home.

The home had 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.

Summary of findings

Staff understood the needs of the people and care was provided with kindness and compassion. People, relatives and health care professionals told us they were very happy with the care and described the service as excellent.

People told us they felt safe and they enjoyed living at the home. Staff had received training in how to recognise and report abuse and had a good understanding of what to do if they suspected any form of abuse occurring.

The home had a robust recruitment and selection process to ensure staff were recruited with the right skills and experience to support the people who lived at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection 12 people living at the home were subject to a DoLS. An application for a further person had been submitted by the managing authority (care home) to the supervisory body (local authority) and had yet to be authorised. The registered manager understood when an application should be made and how to submit one. They were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People's care plans and risk assessments were person centred. They were reviewed regularly to make sure they provided up to date and accurate information.

Staff were appropriately trained and skilled to ensure the care delivered to people was safe and effective. They all received a thorough induction when they started work at the home and fully understood their roles and responsibilities.

The registered manager or deputy manager assessed and monitored the quality of care consistently involving people, relatives and professionals. Care plans were reviewed regularly and people's support was personalised and tailored to their individual needs. People and relative's told us they were asked for feedback and encouraged to voice their opinions about the quality of care provided.

People and relatives knew how to make a complaint if they needed to. The complaints procedure was displayed in the home. It included information about how to contact the ombudsman, if they were not satisfied with how the service responded to any complaint. There was also information about how to contact the Care Quality Commission (CQC).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Systems were in place for recording and managing risk to ensure people who lived at The Shelbourne were safe.

People received their medicines when they needed them and by a suitably trained member of staff.

Robust recruitment practices were followed to ensure staff were suitable and safe to work in the care home.

Is the service effective?

Good

The service was effective. Staff were supported in their role, and they had received an induction into the service.

Staff received regular supervision and training. Staff had received additional training around caring for people living with dementia which enabled them to provide an effective service to people living there.

The registered manager, deputy manager and staff had a good understating of their duties under the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. Staff interacted well with people were kind and compassionate. Staff knew people very well.

Staff respected people's privacy and dignity.

People were involved in the support they were receiving and staff encouraged people to remain as independent as possible.

Is the service responsive?

Good

The service was responsive. People received individualised and personalised care which was regularly reviewed.

People were supported to maintain their relationships with their friends and family.

The home had a system for reporting and acting on any complaints.

Is the service well-led?

Good

The home was well led. There was strong leadership and systems were in place to monitor the quality of the service and to drive improvement.

People and staff were actively involved in the development of the service.

The Shelbourne at Sway

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 17, 18 and 19 August 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed all the information we held about the service. The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also checked to see what notifications had been received from the provider. Providers are required to inform the CQC of important events which happen within the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 people living at the home, the registered manager, deputy manager, seven care staff, the chef, two housekeepers and the activities co-ordinator. We also spoke with a visiting health and social care professional. We looked at eight people's care records, eight recruitment files and records relating to the management of the service. Following our inspection we contacted nine relatives, one visiting dentist and one visiting optician to obtain their views on the homes delivery of care.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe and comfortable, and I sleep well here". Another person told us, "They do look after us here, its excellent, lovely people". Relatives we spoke with following our inspection told us they felt their family members were safe living at the home. One relative said, "I can't fault the staff there. They keep my mother safe and that is the most important thing to me knowing she is safe. Another relative told us, "Staff frequently walk with my father in the grounds to make sure he comes to no harm. It's very reassuring knowing that staff ensure people are safe".

Staff told us they had received training around the importance of protecting people and keeping them safe from potential harm. Training records confirmed staff had undertaken training in protecting people who might be at risk of abuse. There was information on display at the home which provided advice and guidance on keeping people safe. This included the local authority's information leaflets and details of the local advocacy service. The service had policies and procedures in place to safeguard and protecting people. Staff had an understanding of safeguarding and the importance of keeping people safe. They were aware of the various signs and indicators of abuse and neglect. They told us what action they would take if they saw or suspected any abusive practice.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the home or outside agencies when they are concerned about other staff's care practice. Staff told us they would feel confident raising any concerns with the manager. They also said they would feel comfortable raising concerns with outside agencies such as CQC if they felt their concerns had been ignored. Staff understood the whistleblowing procedure and told us they would not hesitate to refer poor practice to managers and other relevant agencies if necessary.

In each of the eight care files we looked at in detail, we saw risk assessments (Dependency Profiles) assessing the risk to the people who lived at the home. For example, falls, mobility, nutrition, medication, decision making, tissue viability and continence. Risks had been assessed and actions had been taken to minimise any risks identified. Assessments were undertaken based on people's individual needs. For example, where one person had lost weight, a risk assessment was carried out to determine their risk of becoming malnourished, and to reduce this risk the person was provided with a high calorie diet and weighed more regularly. A range of other assessments were carried out. For example, the risk of people falling or developing pressure sores. Risk assessments we looked at had been reviewed and updated on a regular basis. Staff told us they were aware of people's risk assessments and what they action they need to take to keep people safe.

The deputy manager told us all incidents were recorded by staff and passed to the registered manager or herself for analysis and lessons learned. For example, one person had recently exhibited behaviours that challenge. A GP and Community Psychiatric Nurse (CPN) had been involved regarding the on-going safe management of the person.

There were enough skilled staff deployed to support people and meet their needs. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. One person said, "I have never noticed a shortage of staff, there may be less at weekends but nothing to put us out" and "If I ring the buzzer they come straight away". One relative said, "I always think they could do with more staff, but I have never felt there were not enough available to give attention". Another relative said, "There always seems to be enough staff around during the day. I've never had to 'hunt' for a carer. There are always staff about".

A health care professional we spoke said, "I think there is always enough staff around". Staff spoken with considered there were mostly sufficient staff on duty, both day and night. We looked at the staff rotas, which indicated systems were in place to maintain consistent staffing arrangements. The registered manager said that staffing arrangements were reviewed in response to people's changing needs.

We looked at the recruitment records of eight members of staff. The recruitment process included applicants completing a written application form with a full employment history. Checks had been completed before staff worked at the home and these were recorded. The checks included taking up written references, an identification check, and a DBS (Disclosure and Barring Service) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults who are at risk, to help employers

Good

Is the service safe?

make safer recruitment decisions. Face to face interviews had been held. The recruitment process ensured people were appropriately skilled and suitable to work with people.

There was a clear medication policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing and disposal of medicines. Staff designated to administer medication had completed a safe handling of medicines course. This had included a practical assessment to ensure they were competent at this task. Medicine administration records (MAR) included an up to date photograph of the person, together with a list of identified allergies. They had been completed to indicate when medicines had been given or had been refused and contained a 'countdown record' to indicate the quantities that were held. These were checked daily and any discrepancies quickly identified and reported to the registered manager for investigation. Staff had access to a range of policies and procedures regarding the management of medicines which were readily available for reference.

People's medicine was stored in locked medicine trolleys that were secured to the wall in the nurse's office's. Medication administration records were appropriately completed. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator and temperatures were monitored and recorded daily. Regular checks and audits had been carried out by the registered manager to make sure that medicines were given and recorded correctly.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. These were stored securely and records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. We checked a sample of the drugs held against what had been administered and found the quantities to be correct. People told us their medicines were always given on time and when they needed them. For example, where people were prescribed 'as required medication' for pain relief records indicated that these were given in accordance with prescribing instructions.

Safety checks had been carried out at regular intervals on all equipment and installations. Fire safety systems were in place and each person had a personal emergency evacuation plan (PEEP) to ensure staff and others knew how to evacuate people safely and quickly in the event of a fire. A 'grab bag' containing PEEP's, torches, two way radios, contingency plans and foil survival blankets was kept at the main entrance to the building. The provider ensured the premises and equipment were maintained. Health and safety records we looked at confirmed regular environmental checks were undertaken and any issues swiftly remedied.

Good

Is the service effective?

Our findings

People told us they were satisfied with the service. One person told us, "It's very good here, I am quite happy with things". Relatives spoken with made the following comments, "It's a friendly and well maintained home", "It's warm and clean" and "I like the homely environment". A visiting dentist said, "It's a very nice home with a wonderful homely atmosphere".

Staff were supported in their role and had been through the provider's own corporate induction programme. An updated induction programme which embraced the 15 standards that are set out in the Care Certificate was in the process of being implemented. The Care Certificate replaced the Common Induction Standards and National Minimum Training Standards in April 2015. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. This involved 'on line' training, attending training sessions, and shadowing other staff. Staff told us they received regular supervision but some staff could not recall having received an annual appraisal. The registered manager confirmed that appraisals had not been carried out annually as they should have but action plans we saw confirmed systems were in place to achieve this by October 2015.

We asked the registered manager what training had been undertaken to support the needs of the people at the home. They told us and staff training records confirmed for example, that 97% of staff had received training in Safeguarding adults at risk, 89% had received training in the Mental Capacity Act and Deprivation of Liberty Safeguarding, 80% pressure area care and 97% in equality and diversity. All care, housekeeping, hospitality, catering and maintenance staff had received training in dementia awareness. Staff were supported by the provider to gain the knowledge and skills to enable them to care for people living at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff had a good understanding of mental capacity and what to do if a person lacked capacity around their care needs. They gave us examples of how they supported people to make choices about what they wanted to wear and what they wanted to eat. Another example given was for a person who had their room cleaned when they were being supported to have a bath, as they did not like to be disturbed when they were in the room. A member of staff told us, "The person becomes quite agitated if we try to clean the room when they are in it so we work around them"

Whilst most people were able to chat about their daily lives, some people were not able to understand and make decisions about their care and support. The registered manager and staff said they would liaise with people's relatives and health and social care professionals should people's needs change so that appropriate care and support was provided. Staff were able to describe the principles of the Mental Capacity Act 2005 and told us when a best interest decision may be appropriate. Care plans for people who lacked capacity showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that where possible the person and other relevant people, such as health and social care professionals and people's relatives had been involved.

We looked at how the service supported people with their nutritional needs. Nutritional screening assessments had been carried out, with any support needed noted in people's care plan. People's weight was checked at regular intervals. This helped staff to monitor risks of malnutrition and support people with their diet and food intake.

People made positive comments about the meals provided at the home. They told us: "The food is excellent" and "We get more than enough". A relative told us, "The food seems good, there are plenty of choices. They give plenty of drinks and there's always juice. Throughout the day staff replenished these as and when required. Care staff recorded food and fluid intake for some people. We spoke with two care staff about this and they were clear about what they were recording and why, which minimised risk of dehydration and poor nutrition.

There was a menu in place which people had been given the opportunity to influence during residents meetings. We looked at the menus which offered at least two choices at each mealtime. One person explained, "We get a choice of

Good

Is the service effective?

main course and pudding. If I don't want that they will always find something I like, they will always make me something". The home had adopted a feed, encourage, assist, supervise and timely (FEAST) system to ensure people ate sufficient amounts. For example, one person living with dementia refused several offers of food at lunch time. Staff gave the person time and re-offered the food in smaller amounts on a smaller plate. Staff told us, "This person would sometimes not eat if they felt it was too much. We therefore offer smaller amounts which they gladly accept". Another person required their food to be pureed. Each element of the meal had been prepared and presented separately on a plate. This helped the person to identify what they were eating and gave them a choice as to what to eat or leave.

Dining tables were attractively set with napkins and the day's menu. The meals looked plentiful and appetising. We noted people enjoying the social occasion of the mealtime experience with lots of chatter and general banter. We saw people being sensitively supported and encouraged by staff to eat their meals.

People were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks. One person told us, "My GP visits occasionally, I can request a visit. The community nurse visits regularly and we are made aware when they are here". People's healthcare needs were considered within the care planning process. Assessments had been completed on people's physical health, medical histories and psychological wellbeing. Arrangements were in place for people's healthcare needs to be monitored.

Records had been made of healthcare visits, including GPs, the chiropodist, optician and dentist. A visiting health care professional told us, "They contact us when needed in relation to supporting people. They work with us to get the best results for the person".

Good

Is the service caring?

Our findings

People told us they were treated with kindness and compassion. One person said, “It’s fine here. Everybody is nice and kind.” Another person told us, “I couldn’t wish to be in a better place. The staff are all so kind and caring. I’m very well looked after indeed”. One relatives told us, “Staff are friendly, they all come and talk to us, they are so caring”. Another relative said, “The staff have been wonderful to my mum, very caring and sensitive”. A visiting health care professional told us, “The care they are giving here very good. I have no concerns at all”. People said their privacy and dignity were respected. One person told us, “Staff say it’s a pleasure to help me, they treat me with respect”.

During the inspection we observed staff interacting with people in a kind, pleasant and friendly manner and being respectful of people's choices and opinions.

People were assisted in a considerate, polite and reassuring manner by staff. People spent time in the privacy of their own rooms and in different areas of the home. Staff respected people’s privacy and we saw they knocked on people’s doors before being invited to enter. Staff were discreet when delivering personal care and were sensitive when offering support or assistance.

People were involved in their day to day care through regular reviews of their care. People’s relatives were invited to participate each time a review of people’s care was planned. A relative told us, “I get invited to all my husband’s care reviews. I always know what’s going on. The manager is very good at keeping me informed”. People’s wishes and the decisions they had made about their end of life care were recorded in their care plans when they came into the home. When people had expressed their wish regarding resuscitation this was clearly indicated in their care plan and the staff were aware of these wishes.

People told us staff would sit and talk to them about their working life and family and we saw this happened frequently throughout the day. We observed staff actively listened to people, particularly when someone was requesting something, clarifying what they wanted.

Staff responded sensitively when people were restless or agitated and spent time trying to help them feel more settled. For example, one person was clearly upset and staff gave plenty of reassurance, engaging in ways to help calm the person’s anxiety, such as, stroking their hand and offering a cup of tea. Staff we spoke with said they were aware that sometimes people needed attention and conversation and they tried to include this as much as possible. We saw in one person’s care plan that talking to them offered reassurance and helped them to feel calm and we saw staff facilitated this effectively.

People were encouraged to be as independent as possible, in accordance with their needs, abilities and preferences. One person told us, “There are no restrictions, I’m independent, they come when I call. I still feel in control of my own life”.

Residents’ meetings were held regularly. These helped keep people informed of proposed events and gave people the opportunity to be consulted and make shared decisions. One person told us, “We have a residents meeting now and then, we discuss things generally”. We looked at records of meetings which showed various matters had been raised and considered.

Staff understood their role in providing people with care and support. There was a ‘keyworker’ system in place, this linked people to a named staff member who had responsibilities for overseeing aspects of their care and support. Staff were aware of people’s individual needs, backgrounds and personalities. They gave examples of how they delivered care and promoted people’s independence, dignity and choices.

Good

Is the service responsive?

Our findings

People told us staff responded to their needs quickly. One person said, "When I ring my call bell staff come as quickly as they can". Another person told us, "When I need help staff are only a moment away. I never have to wait long and the staff are only too willing to help me".

Staff knew people well and understood their needs and preferences. For example, we asked staff about people they were working with that day and how they preferred to be supported. All knew about people's needs and preferences in detail. For example, one member of staff described how one person would eat better in the dining room, or if staff sat with them. One person told us, "The carers are delightful. They now what you want before you ask for it".

Staff told us they put the person at the centre of everything they do. Care plans contained clear information about people's physical and emotional needs. Detailed assessments had been completed before people came to live at the home. The care assessment process took into account people's previous lifestyles and personal histories. Consideration was given to their cultural and social backgrounds, their interests and aspirations. Care plans contained detailed information about the person life history. For example, their favourite things, what they didn't like, things that made them laugh, something you might like to know about them. Information such as their favourite food and about the person's family.

The risk assessment and care plans were split into sections with a separate section for recording assessments and care planning around mood, activities, personal care, skin, medication, nutrition, hydration, mobility and continence. One visiting healthcare professional told us, "They do a lot of information gathering using a 'life story' format, which can be helpful when caring for people with a dementia". The deputy manager told us they regularly updated the information as they learnt more about people whilst undertaking activities with them.

People were involved as much as possible with planning and reviewing their care. One person said, "We went through the care plan together". Relatives indicated they were involved informally with this process, one commented, "Support is given with care needs a priority. They are not missing anything". Processes were in place to monitor and respond to changes in people's needs and circumstances. We saw the care plans had been updated on a monthly basis or more frequently if people's needs changed.

People and / or their relatives had signed their care plans, which confirmed their agreement and involvement with the content. Some relatives had Power of Attorney (PoA) in respect people's welfare. A PoA is a written document that gives someone else legal authority to make decisions on your behalf. Copies of those documents where relevant were kept in people's personal financial records which were kept securely in the administration office.

Health care professionals spoken with indicated the service was responsive to the needs of the people living at the home. One told us, "They ask for help and support and work with us to get the best approach for the person. They have adapted their work practice in response to people with dementia".

People were supported to maintain their relationships with their friends and family. Visiting arrangements were flexible and people could meet visitors in the privacy of their own rooms. One relative told us, "We can call anytime whenever, it's an open house". People indicated they were generally satisfied with the activities provided, including the visiting singers and regular church services. Relatives told us of the many events which had taken place. For example, at the time of our visit the home was hosting an 'art exhibition'. Work by local artists was displayed in both the Lyndhurst lounge and Library. People told us they enjoyed looking at the work and that it was nice to involve the community.

The home employed two activity co-ordinators which enabled them to cover weekends to ensure activities happened every day. We spoke to one activities coordinator who was passionate in their approach to activities and was aware that meaningful activities should not focus solely on events and timetabled activities. Daily activities included, giant team scrabble, crossword club, flower, garden croquet and minibus trips. On the afternoon of our visit there was a Pets as Therapy (PAT) dog who regularly visited the home.

People's rooms were personalised and furnished with their belongings, such as their own furniture, photographs and ornaments. The home worked with people and their relatives to ensure they felt at home as much as possible.

Good

Is the service responsive?

People understood the complaints procedure and processes. One person told us, “I have not needed to complain at all, but I would speak to the manager if I needed to”. A relative said, “No grumbles, I would go to the manager if I had a complaint I think she would deal with it”. The complaints procedure was displayed around the home and in reception and was included in the guide to the service. We found the service had systems in place for the recording, investigating and taking action in response to complaints. There had been 23 complaints raised at the home within the last 12 months. Records seen indicated the matters had been investigated and resolved in a timely manner and to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

People made positive comments about the management and leadership arrangements at the service. One person told us, "I think it's well managed, the managers always ask how I am. The manager is very nice she is very good at dealing with people". A relative said, "I think the manager is very good, I could go straight to her if needed". Visiting health care professionals spoken with told us they had 'no problems' with the management of the service. One commented, "I think the home is well managed".

Staff told us they thought the home was well led. One member of staff told us they "loved working here" and said "we all work as a team it's really good. Another member of staff told us there was a friendly, open culture in which they felt they could approach managers at any time to discuss relevant matters.

There were clear lines of accountability and responsibility. There was a deputy manager and team leaders with designated responsibilities for the day to day running of the service.

Each morning at 10am the registered manager or deputy manager held a '10 at 10 stand up meeting'. All heads of departments and team leaders attended. The meetings were designed to discuss and communicate any concerns that had arisen during the previous 24 hours and to talk about any impending issues into the next 24 hours. Staff told us they found this a good way to communicate 'what was going on in the home' and enabled them to keep up to date with the day to day running of the home and people's changing needs.

Falls and other incidents were recorded and monitored through a monthly falls and accident analysis. The registered manager's quality assurance system included monitoring and analysing accidents and incidents. The records we looked at showed that when the registered manager identified possible causes of accidents and incidents, they took action to minimise the risk of a reoccurrence. For example, one person was assessed as having a high risk of falls. The person's medication was reviewed and slowly reduced. The person's physical health had now improved so they were now at lower risk of falls . Risks were looked at on an individual basis and their needs were met. Potential risks were reduced as much as possible.

The management team was supported and monitored by the registered providers. Staff spoken with indicated the registered manager and deputy manager were supportive and approachable. People indicated there was an open and friendly atmosphere at the service. There were systems and processes in place to consult with people who used the service, relatives and staff. Relatives confirmed communication systems were good.

The provider had a system in place to monitor the quality of the service and to drive improvement. This included monthly audits completed by the registered manager. The management support team visited the home frequently and spent time discussing the service with people and staff. They recorded what they found and an action plan of any issues that needed addressing was put in place. The audits covered areas such as training, care plans, management of medicines, infection control, staffing and supporting staff. These were reviewed as each audit was completed. Action plans clearly stated the required action and a date by which it should be completed.