Shawe House Nursing Home Limited

Shawe House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We carried out this unannounced inspection on 7 July 2014. The previous inspection was in April 2013. There were no breaches of legal requirements relating to the areas inspected on that occasion.

Shawe House is a nursing home registered to provide accommodation and nursing care for up to 33 older people. 30 people were living at the home on the day of our inspection. Shawe House specialises in providing care and support to older people living with mid to late stage dementia.

Summary of findings

There was a registered manager in post at the date of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The registered manager was also managing another home and spending 50% of her time at Shawe House. Some relatives expressed concern that the manager was not as present as she had been before. Staff stated they were happy with the management arrangements, but we considered that the partial absence of the manager had affected the quality of life for people living in the home.

We saw that people who were mobile were able to move around the corridors freely but that the corridors were narrow and this posed a risk, which needed to be monitored. We found concerns relating to a blocked fire escape and a potential trip hazard on the slope leading to the garden.

There was musical entertainment provided on the afternoon of the day we were there, and there were regular entertainments, but there was scope for more activities designed specifically for people living with dementia.

Family members told us the staff worked very hard and provided a good quality of care. The staff we saw and spoke with were enthusiastic, and were gentle and kind towards the people they were helping. We saw that some people were given less attention from the staff than others.

From January 2013 to March 2014 Shawe House had failed to submit to the CQC notifications of deaths, which they are required to do under the regulations.

The registered manager was aware of the home's responsibilities under the Mental Capacity Act 2005, the supporting code of practice and the Deprivation of Liberty Safeguards (DoLS). At the date of our visit there was one application in progress for authorisation under DoLS. Such an authorisation is needed when people who lack the capacity to consent have their liberty restricted.

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?

Requires Improvement

In some respects safety could be improved.

We spoke with three family members of people living in the home, who said they felt their relatives were safe and well looked after in Shawe House. Staff were trained to recognise any instances of abuse and knew how to report it. We knew from our records that safeguarding incidents were reported and dealt with.

People were able to move around the home freely, if they were independently mobile, but we were concerned that the corridors were quite narrow if two people were passing, and risks needed to be monitored. There were further areas for improvement. We saw that one upstairs fire escape was blocked by a chair when we arrived, posing an obstruction in the event of fire. There was also a missing safety rail on the side of the path leading to the garden, which was lying on the floor and posed a trip hazard.

Staffing levels were good in terms of the numbers of staff on each shift, although staff worked long shifts with short breaks. This potentially meant staff would become tired when supporting people towards the end of their shift.

Shawe House had recently submitted an application for a Deprivation of Liberty Safeguards (DoLS) authorisation, and was following correct procedure in relation to DoLS and the Mental Capacity Act 2005.

Is the service effective?

Good

The service was effective.

Health needs were monitored and recorded in care plans, and people had access to GPs and other health professionals. One family member mentioned that they had sometimes brought their relative's health issues to the attention of the staff.

Breakfast was regarded as the most significant meal of the day, which helped people living there to remain well-nourished. People were assisted to eat as needed, and families were encouraged to be present at mealtimes to support their relative.

Staff were well trained and received ongoing training and supervision. There were cleaners working at the home but one of the bedrooms had a strong smell of urine.

Is the service caring?

Requires Improvement

Some aspects of caring required improvement.

Summary of findings

There were sufficient staff available to attend to people's needs. However we observed that some people received less attention than others.

Name plates on doors were out of date, missing or had the wrong name, which was disrespectful to people living in the home. We were told of plans to replace the name plates. There were no aids to assist people to recognise their rooms.

Care files were well laid out and thorough. We saw evidence they were reviewed regularly. Attention was paid to end of life planning, where appropriate, to ensure a dignified death.

Is the service responsive?

Good

The service was responsive.

Care files showed that care was planned in detail to respond to people's changing needs.

Entertainment was provided with a pub afternoon on Fridays and musical entertainments at other times. Not everyone could take part in these entertainments and we found that there was scope for more activities.

Regular meetings were held with relatives to allow them to raise issues and ideas. Shawe House had previously sent round quarterly questionnaires but these had not been used since August 2013.

Is the service well-led?

Requires Improvement

The leadership of the service required improvement.

The registered manager was spending half her time managing another nursing home. A clinical lead was sharing the management responsibilities. Relatives told us the manager had been present less often than previously. We found that certain issues could be attributed to a lack of managerial involvement in Shawe House especially in recent months.

We also discovered that there had been six deaths over a period of 14 months which had not been reported to the Care Quality Commission as required by regulations. This meant that the CQC had been unable to monitor these events at Shawe House. We requested and received retrospective notifications.

The registered manager carried out regular audits and reported to the provider.

Shawe House

Detailed findings

Background to this inspection

We visited Shawe House on 7 July 2014. The inspection team was an inspector and an expert by experience who had knowledge about care for the elderly.

Before the inspection we reviewed the 'provider information return' (PIR) which was a document completed by the registered manager in June 2014 giving information about the home. We also examined previous inspection reports, and considered all the information held by the Care Quality Commission. This included the service's Statement of Purpose, which had been updated in March 2014. This is a document setting out the aims and objectives of Shawe House. We contacted the local authority which commissions care at Shawe House and received feedback from their recent visits.

On the day of the inspection we spent time observing people in various areas of the home including corridors and the lounges. We were shown around the building and saw people's bedrooms, bathrooms, and the communal areas. We also spent time looking at records, which included a sample of people's care files, and records relating to the management of the home.

We found that all the people living at Shawe House were unable to tell us meaningfully about their experience of living there. This was because they were living with either mid or late stage dementia. Instead, we used a specially designed method of observation, called SOFI

(Short Observational Framework for Inspection). SOFI is a specific way of observing care which can help us understand the experience of people who can not talk with us.

We also spoke with five family members who were visiting on the day of our inspection, six members of the care staff, the clinical lead and the registered manager. We reviewed one care plan in detail and looked at three others. We saw the responses from relatives' questionnaires.

Requires Improvement

Is the service safe?

Our findings

People living in Shawe House were not able to tell us about their experience of living there and whether or not they felt safe. Instead, we spoke with five family members who were visiting their relatives on the day of our inspection. Two of them were very frequent visitors, four or five times a week, so had very good knowledge of the service. All of the family members were positive about the way their relatives were looked after, and in particular about the care that staff took to ensure they were safe. One family member said: "The lounges are always manned. Somebody is watching her all the time." The registered manager told us, and we saw, that this was facilitated by the presence of a nurses' desk in each of the two lounges, which is where nurses or other care staff would complete paperwork, while being present in the room with the residents.

We looked at how Shawe House protected people from abuse. One family member said: "There is no sign of bullying or harassment here." We talked with six members of the care staff including two nurses. They told us that they had received thorough training in safeguarding during a three month probationary period, and that this was regularly refreshed afterwards. The policy of the home was to train all staff in safeguarding to the level appropriate to their role. According to the provider information return 96% of staff had received training in safeguarding within the last two years. We asked one care assistant about their understanding of safeguarding and what possible types of abuse they would look out for. They were able to outline clearly the various forms of abuse that might occur within this setting. We asked what they would do if they witnessed any abuse or suspected that it might have taken place. They knew who to report it to within the home – namely the registered manager or the clinical lead – and understood the process that would be followed. This showed that this member of the care staff had a good understanding of safeguarding and the measures to be followed to protect people from harm.

Since the previous inspection in April 2013 Shawe House had reported three safeguarding incidents to CQC. These had been referred also to the local authority and appropriate action had been taken where necessary. This showed that the provider was aware of their duties to report such incidents so that the local authority could investigate and make recommendations to protect people from similar incidents in the future. There had been no reports of whistleblowing since our last inspection (whistleblowing is where a member of staff or former member of staff reports an incident of concern within the home). However, the staff we spoke with said they knew the home's whistleblowing policy and would have no hesitation in reporting such an incident outside the home if they felt it necessary.

The registered manager explained to us that the aim of Shawe House was to allow people as much freedom as possible, provided they posed no risk to themselves or to other residents. Those who were independently mobile were encouraged to move around the ground floor. There was a gate operated by a keypad at the foot of the stairs to prevent anyone from venturing up the stairs alone. We observed that the corridors on the ground floor were quite narrow, which represented a risk as people were moving along them at different speeds, not necessarily aware of each other's presence. We mentioned this to the manager who stated that the home was seeking planning permission to extend the building on the ground floor, which would allow one corridor in particular to be widened. In the meantime, staff needed to be aware of people's movements as the corridors were not all in view of the two lounges where staff were stationed.

We were told that two people always slept in chairs in the lounges downstairs. This was recorded in their care plans, and had been discussed and agreed with their families. Staff were present to observe them as they slept and therefore they were safe. One family member told us: "My relative likes to sleep in a chair and they meet her needs by enabling her to do that. She's as safe as she can be."

There were three fire escapes leading from the first floor by staircases down to the ground. We saw at the front of care plans a personal emergency evacuation plan which described how each individual would be enabled to leave the building in the event of a fire. During our tour of the building we saw that access to one of the fire escapes at the end of a corridor was blocked by a chair, which posed an obstacle in the event of an emergency. A nurse removed the chair immediately.

On the ramp leading down into the garden from the main lounge the handrail attached to the wall had fallen off and was lying on the ground. We understood that the wall

Requires Improvement

Is the service safe?

suffered from damp and the handrail could not be replaced until a new damp course was in place. Until a repair was effected this represented a safety hazard. No measures had been taken to reduce the risk.

The home had cleaners working throughout the day but we noticed that some areas were not clean. There was some food dropped in one of the downstairs corridors which remained there until it was trodden into the floor. We also noticed that there was a strong smell of urine in one of the upstairs bedrooms. We were told that there was a plan to replace the carpet in that room with wood effect flooring which would make it easier to clean.

We saw that medication was stored securely, and was administered by one of the nurses on duty. New nurses were required to do a minimum of five supervised medication rounds before they did one on their own. This enabled them to get to know the residents well and reduced the risk of medication being given to the wrong person.

On the day of our visit there were two nurses: an RGN and an RMN (registered general nurse and registered mental nurse). There were five care assistants. In addition the clinical lead who was a qualified nurse was usually present five days a week, and the registered manager was present approximately half the time, as she also managed another care home nearby. At night there were one nurse and three care assistants. One person was receiving 1 to 1 observation during the night. This was provided by an additional member of staff.

These numbers meant there was adequate staffing for the numbers of people in the home, although this needed constant monitoring relative to their needs.

Shawe House had not submitted any notifications to CQC about DoLS authorisations during the past 12 months. A DoLS (Deprivation of Liberty Safeguards) authorisation is needed when a person's liberty is restricted and the person lacks the mental capacity to consent to that restriction. An application for an authorisation had been submitted on 28 May 2014, but it had not yet been authorised by the supervising authority (Trafford Council). There was no paperwork relating to the application on the person's care file, which would have enabled care staff to be immediately aware of the restriction on the person's liberty. Such a restriction is covered by an 'urgent' authorisation until the application under DoLS is authorised. The home is not obliged to notify CQC of an application until it is either granted or refused, so was within its reporting obligations.

Good

Is the service effective?

Our findings

We observed the meal at lunchtime. Some people were seated at tables in one of the lounges, but most people ate in their lounge chairs. Because of their limited ability to communicate people did not express a preference verbally, but staff told us they knew where people liked to sit. The food on offer was either pizza or vegetable soup, and staff said they knew what people preferred. For some people soup was more suitable because it was easier to swallow. We saw that staff patiently and sensitively helped one person to eat, despite their apparent reluctance.

Family members were encouraged to stay during mealtimes and to help their relatives to eat, if needed. One family member said: "[My relative] is well nourished. They would refuse to eat if they didn't want it. Their food is pureed because they have problems with swallowing." We saw weight charts were kept on each care file to monitor any significant changes in weight.

Breakfast was the most substantial meal of the day, and people could eat all or some of a full English breakfast. Breakfast began at around 8.45am but people could arrive at different times and we saw people still eating beyond 10am. The registered manager told us that the local dieticians were so impressed by the success of the breakfast provision in ensuring people received a hearty breakfast that they had invited her to talk about how it was done to a group of care home managers.

The menu was on a two week rotation and we saw that it provided a mix of food, which would facilitate a balanced diet. Drinks were provided throughout the day and we saw staff serving drinks to people in appropriate receptacles and encouraging people to drink them. This was important as the majority of residents were unable to ask for drinks themselves.

The registered manager told us that people's health needs were constantly monitored, and this was confirmed by the care files we looked at. GPs visited the home regularly and people had access to other health professionals. One family member said: "They get the doctor in if there is a problem and they let me know what the doctor has said. They ring up and tell you if anything has happened."

However, one visitor told us that they had become aware of a series of health problems suffered by their relative, which they had drawn to the attention of staff. They stated: "They act when I tell them."

We saw that medication was provided as needed to enable people to maintain their physical and mental health. The registered manager told us that her preferred approach was to reduce rather than increase medication. This was confirmed by a family member who told us that when their relative had come into Shawe House they had been on high doses of a variety of medication, but this had been gradually reduced with the agreement of their GP, and they were now taking no regular medication, and their mood and behaviour was greatly improved. The manager stated that Shawe House's policy was not to use medication to control people's behaviour, but instead provide sufficient staff, and not interfere with behaviour except where necessary.

We asked members of staff about the training they had received. They told us all new starters went through a three month probation period which covered core subjects. This was also referred to in the provider information return we received before the inspection. We spoke with a member of staff who had been given the responsibility of training both new and existing staff. They had attended a 'Train the Trainers' course. They told us that all staff had either gained or were working towards gaining a QCF/NVQ Level 2 or 3 (QCF is the Qualifications and Credit Framework). A member of staff said: "They do try to get us as much training as possible."

All staff had a monthly supervision and an annual appraisal with their line manager or a nurse, as appropriate.

Requires Improvement

Is the service caring?

Our findings

Seven staff were on duty on the day of our visit which we confirmed was the normal minimum complement. The registered manager stated that staff were encouraged to spend time chatting with people living in the home as part of their job role. We observed that the meal times were busy but at other times staff were able to engage with people in a relaxed manner. When we did our SOFI observations in the main lounge we saw that some people were regularly approached by staff, especially those who could respond in some way, but that others were largely ignored. We saw this was also the case in the "quiet" lounge where most people were immobile and in the later stages of dementia. One person who was quite vocal was attracting the attention of staff but we saw little interaction with other people. The staff should be encouraged to attend to the needs of everyone equally.

One family member said: "My [relative] has had a number of urinary infections which have been treated by antibiotics. The GP comes out when requested. However, this might be better treated by not leaving toileting until the last minute." Another person said: "If they were at home they would get better care." On the other hand, another person said: "The staff are absolutely fantastic. They cope really well." We saw one member of staff kindly pulling a curtain in the quiet lounge to shield someone's eyes from the sun.

Other family members commented favourably on the care assistants. One said: "all the care assistants at Shawe House are held in high regard." Someone else had written in response to a questionnaire: "Very friendly, relaxing and caring. Made to feel very welcome from day one of [my relative] coming into your home."

Six nurses were identified as key workers for individual residents and there was a list on a noticeboard in the corridor enabling family members or visiting professionals to see who each person's key worker was. One member of staff said: "We pay a lot of attention to residents to ensure they get the best." Another one said: "If that was my grandad here, that's how I would want him to be treated."

Shawe House had held Trafford Council's Dignity in Care award for several years. We found, however, some concerns relating to treating people with dignity. We were shown around the home at the start of the day and noticed that some of the bedroom doors had incorrect name plates. For example one double room had two names on the door. One person had died and the second had moved to another room. The person who now occupied the room did not have their name on the door. Several other rooms had an incorrect name plate or no name plate. We mentioned this to the registered manager who said that she intended to replace name plates with lettering for people's names. Until this was done, we considered that causing people to live in rooms with someone else's name on the door was undignified.

There were no memory boxes or other aids to assist people to recognise their rooms, of the kind that are often used for people living with dementia. The registered manager intended to put up photograph frames and had asked family members to bring in suitable photographs.

End of life planning took place when appropriate. Family members told us: "There are agreed end of life care plans in place here," and "I have completed a form – they ensure that there is dignity at all times." For six people an 'Allow Natural Death' form had been completed. This form included the 'Do not attempt resuscitation' order (DNAR) and also contained other details relating to the family's wishes. The form was signed by the person's GP and included a record of which family members had been consulted. In a case where there were no family members available the GP recorded their assessment that their patient was unable to comprehend the decision. There was also a mental capacity assessment on the file.

The registered manager told us it was the home's policy to facilitate people at the end of life to die at Shawe House where possible, as it was their home. We saw from notifications submitted to us after the inspection that this policy was put into practice. Even when people had been admitted to hospital they often returned to Shawe House for the end of life. This showed that Shawe House was trying to improve people's dignity and comfort. The clinical lead was studying the 'six steps' programme, which is a programme for developing and improving end of life care in residential and nursing homes.

Good

Is the service responsive?

Our findings

We examined one care file in detail and looked at three others. Each file was very well organised and indexed, enabling staff and others to find individual sections easily. There was a record of visits by health professionals, and a care plan divided into 17 separate sections. Even though the person was unable to communicate verbally, the instruction was given: "[the person] might understand some of what is said to them so staff should explain all intervention to reduce their anxiety." This showed a sympathetic understanding of a person living with dementia.

Each care plan had been reviewed monthly and staff signed to show they had reviewed the plan even if there had been no change. Family members were encouraged to take part in the reviews of care plans. On one file the nearest relative had signed below the statement "I confirm that I have been given the opportunity to discuss the needs of my family." This meant that when family members wanted to they could be involved in planning the care of their relatives.

On the afternoon of our inspection there was a visiting musical entertainer. Many of the residents seemed to be enjoying his songs. The registered manager told us she was increasing the number of such events as people clearly enjoyed them. A 'pub afternoon' took place on Fridays, with alcohol-free beer and a live singer, which families were invited to attend. We were told this was a popular event with many of the people living in Shawe House. On other days in warm weather there was a pleasant garden which people could sit in.

We observed that most of the people sitting in the quiet lounge who were not able to move independently were not taken through to the other lounge for the musical entertainment. They were not able to express the wish to take part, so it was difficult for staff to know whether they wanted to or not, but no-one tried moving them.

There had previously been an activities co-ordinator but the manager told us this post had been discontinued. More recently the manager had asked relatives what provision for activities they wanted. One family member told us there were "no activities except on Fridays." We considered there was scope for more activities to be made available including for the less mobile people and those in the later stages of living with dementia.

Shawe House held 'residents/relatives' meetings which allowed family members to express their views about issues affecting their relatives. The registered manager told us the minutes for the last two meetings had not yet been typed up, but we saw her notes and an action plan created on the basis of points raised at the meeting. This showed that the interests of people living in the home, as represented by their family members, were taken into account.

Questionnaires had been sent in the past to the families of people living in Shawe House. This allowed the views of those family members who did not attend the meetings to be obtained. The last one had been sent out in August 2013 and we saw some of the returned questionnaires.

The registered manager stated in the 'provider information return' that the questionnaire was sent out every three months to one quarter of the families in order to achieve a steady return of information and so that every family would be contacted over the course of a year. However, no questionnaire had been sent for 11 months. We were told this was due to the absence of a member of staff on maternity leave since October 2013. We considered that the management could have taken this task on or delegated it, in order to maintain the use of questionnaires.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had become the registered manager of another home acquired by the same provider in March 2014. The plan at that time was that she would spend 50% of her time at each home. Day to day management of Shawe House would be shared with the clinical lead, who had been in that post since August 2012.

The registered manager told us that her hours had been "unorthodox" in the first few months of establishing the other home. The perception of family members was that she had been present much less than before. Comments included: "She isn't here very often" and "we don't see [the manager] much." One person observed: "There is a lack of leadership for the staff." The registered manager told us she intended to put up a timetable in a public area so that both staff and visitors could see the times she planned to be at Shawe House. We spoke with the clinical lead who said they thought the manager had divided her time equally between both homes. The clinical lead stated that they were comfortable in the role and were given autonomy to take decisions. If there was a significant event they would take necessary action and discuss it subsequently with the manager.

Comments from family members showed that they had not yet adjusted to the reduction in the manager's time at Shawe House. There were however other factors which indicated that less attention than previously was being devoted to the management function. We talked with one fairly new member of staff. They said that when they started they did not know who the manager was, and they only met the manager after a week or so in the job. Another member of staff had been working at Shawe House for about six months; their photograph had not yet been placed on the board with photographs of all staff. No staff meetings had taken place recently. The registered manager told us that they spoke to staff individually. There had been a staff questionnaire in June 2014. One member of staff told us: "The only positive feedback I get is from family members and colleagues." All of the above factors indicated that the registered manager was not taking a constant interest in the operation of Shawe House.

During our visit the clinical lead who was herself a nurse and the registered manager who was present were both involved with entertaining residents. They encouraged clapping and singing to music, and were involved in serving lunch. However, several family members independently told us that it was unusual for the managers to be involved in this way. One person who wrote to us immediately after the inspection described it as "window dressing" for our benefit, and said it was many months since the managers had helped serve lunch to people. They added: "it is a far cry from the norm when, on many occasions, just two care assistants (and sometimes one only) struggle to serve 10 or 12 residents and assist some of them to eat." Another family member described themselves as "staggered at the show they put on on Monday afternoon" (the day of our visit). A third person said: "The presence of the management at mealtimes is unheard of."

We became aware of two concerns in relation to staffing. Although there were good numbers of staff on each shift, the staff were mainly working long shifts: the nurses 8am to 8pm and the care staff 8am to 9pm. During each shift they received three ten minute breaks, less than their legal entitlement under the Working Time Regulations 1998. This could cause tiredness and pose a risk to people living in the home. One family member commented: "The staff are excellent but run ragged."

The second concern was expressed by two family members, about staffing levels at weekends. One said: "At weekends they could do with an extra person. You can wait a long time to be let in." Another opinion was: "There are not enough staff, particularly at weekends." The registered manager told us however that staff numbers were equivalent at weekends to during the week.

Services are required under regulations to notify the CQC about deaths of people within the service. Prior to the inspection we had noticed that there had been a long period, from January 2013 to March 2014, when we had not received such notifications. We raised this first with the clinical lead who initially could not say whether there had been any deaths in that period. However, we were told later that there had in fact been six deaths within that period. The registered manager explained that most of them had been around March/April 2013 when personal circumstances may have diverted her attention. However, the clinical lead could have sent in notifications and was in post at the time; they sent in four more recent notifications (March to May 2014). Following the inspection we requested the registered manager to send us the outstanding notifications retrospectively, which was done.

Requires Improvement

Is the service well-led?

The registered manager explained the quality monitoring systems operated by the provider. She met with the operations director every week. The operations director would spend the day at Shawe House, talking with staff and visitors, and inspecting audits carried out by the registered manager. The registered manager met with the other directors in alternate months. No written report was submitted to the directors. In addition the market relationship officer (MRO) of Trafford Council visited roughly every three months and produced a report. We had contacted the MRO before our visit and seen their latest reports, from November 2013 and January 2014. The MRO stated in July 2014: "Although there are some recommendations however most of these are what is seen as best practice, and I don't have any concerns and feel that they manage the client group very well."