Care Quality Commission

Random inspection report

Care homes for older people

Name:	Shire House
Address:	Sidmouth Road Lyme Regis Dorset DT7 3ES

The quality rating for this care home is:	zero star poor service
The rating was made on:	

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this review a 'key' inspection.

This is a report of a **random inspection** of this care home. A random inspection is a short, focussed review of the service. Details of how to get other inspection reports for this care home, including the last key inspection report, can be found on the last page of this report.

Lead inspector:	**Date:**							
Susan Hale	1	8	0	1	2	0	1	0

Information about the care home

Name of care home:	Shire House
Address:	Sidmouth Road Lyme Regis Dorset DT7 3ES
Telephone number:	01297442483
Fax number:	01297442483
Email address:	
Provider web address:	

Name of registered provider(s):	Sentry Care Limited
Name of registered manager (if applicable)	
Type of registration:	care home
Number of places registered:	22

Conditions of registration:		
Category(ies) :	Number of places (if applicable):	
	Under 65	Over 65
old age, not falling within any other category	0	22

Conditions of registration:
The maximum number of service users who can be accommodated is 22
The registered person may provide the following category of service only: Care home only - Code PC to service users of either gender whose primary care needs on admission to the home are within the following category: Old age, not falling within any other category (Code OP)

Date of last inspection								

Brief description of the care home
Shire House is established in a large detached house set in its own grounds on the western outskirts of Lyme Regis. The home is accessed by a driveway and is surrounded by mature grounds and gardens there is level access to most parts of the gardens. There are large parking areas at the side of the house for visitors

Brief description of the care home
convenience. The original Edwardian house has been extended to provide additional bedrooms. There are two communal lounges and a separate dining room on the ground floor. People who live at the home are accommodated on the ground, first and second floors of the home and a passenger lift is available to the first floor for less ambulant residents. There are eighteen single and two double bedroomsuites, all of which are decorated to a good standard. Of the twenty bedrooms, eighteen have ensuite facilities. There are sufficient communal bathrooms and WC s to meet the needs of residents, including an assisted bath. Shire House provides 24-hour personal care, all meals, laundry and domestic services.

What we found:

The visit by two inspectors took place on the 18th January 2010. The purpose was to check if the home had complied with the statutory requirement notice issued by the Care Quality Commission on the 23rd December 2009 in relation to breaches in the Care Homes Regulations 2001 relating to poor care planning practice.

We found that both residents who did not have a care plan at the last visit now had one in place and they have both been signed by the residents concerned.

The first care plan contained a photograph of the person, a very brief life history, a partial nutritional and pressure sore risk assessment and care plans covering topics including, maintaining health and personal care, cognition, maintain quality of life safely, falls and monitoring review forms, pressure areas and socialising.

On the first care plan although it was noted that the person had two significant food allergies there was no care plan or risk assessment in relation to this and no information and guidance on file for staff to follow should the person have an allergic reaction.The cook was aware of one but not the other food allergy. The information about the food allergy was not included on the care plan on how to maintain quality of life safely.

The care plan relating to falls was dated 17th December 2009 but had not been updated to reflect a fall that had occurred on 15th January 2010. The moving and handling assessment was dated 5th January 2010 which recorded that the person was at low risk. This had not been reviewed and updated after the fall that had occurred on 15th January 2010. The falls risk assessment had been wrongly calculated as it didn't include the recent fall or that the person used walking aids. The risk assessment relating to 'unsteadiness on feet' made no reference to the fall on 15th January 2010.

Fluid charts were in place but the amount taken each day had not been totalled and there was no evaluation made to see if the person was receiving enough fluids. Daily records were in place but the majority were very brief and a record of tasks undertaken by staff.

On the care plan it clearly stated the need to encourage the person to participate in activities (in the cognition and socialising care plans) . However the only activities recorded in January were 'chat' and there were no entries on the activity record for nine days in January 2010.

The key worker input and dependency record were both blank.

The second care file looked at contained the persons next of kin details, list of medical conditions and an initial assessment that had been completed in December 2009. All topics had been reviewed on 14 January 2010. A care plan in relation to catheter care was detailed and reflected the persons current needs. Fluid charts were in place with a recommended daily intake of 1500 ml. However, the fluid charts were not totalled each day, the amount of fluid in the jug was not recorded, and the fluid charts were not evaluated to see if the person was receiving enough fluid.

The personal cleansing record showed that the bedlinen had been changed on 3rd

January 2010 and 16th January 2010 meaning that it had been used for thirteen days.

The social activity plan which started on 1st January 2010 recorded ' chats' on four days with no entries made on eight days. this is despite a cognition and socialising care plan which states' encourage to participate in activities every day'. There was no evidence that any activities had been offered to the person concerned.

The care plan clearly records that the person needed a high fibre and high protein diet due to medical conditions. There was no evidence on the care plan or daily records that this was provided and the cook was unaware of any resident in the home needing these special diets.

In common with all care plans the dependency assessment and the key worker assessment was blank and the pressure sore and nutritional risk assessments were incomplete.

On the third care plan looked at there was clear evidence that the person had fallen on the daily record but this had not been recorded in the accident book and had not led to the care plans and risk assessments being reviewed or updated. The physical assessment and care plans were dated November 2009. However, the deputy manager told us that the person was now (January 2010) at the end stages of their life and had signed a declaration to make clear their wishes to remain at the home and not be admitted to hospital if they became ill. However, the care plans and risk assessments had not been updated to reflect the deterioration in physical health and increased frailty of the resident.

The personal cleansing record showed that the last time the bedlinen had been changed was 8th January 2010 meaning that the linen had been used for 10 days.

The daily record showed that the person had fallen on the 6th January 2010 but this was not recorded in the accident book.The falls risk assessment and care plan relating to mobility had not been updated to take the fall into account.

In common with all other plans looked at, on the fourth care plan the dependency assessment and key worker input was blank and pressure sore and nutritional risk assessments were incomplete. The mobility care plan detailed that the person had a history of falls and continued to be at high risk of further falls. However, it went on to state that the person' knows their own limitations' although the psychological profile makes it clear that the person has short-term memory loss and was confused. It is therefore difficult to see how they would be able to be aware of their own limitations. The moving and handling risk assessment did not give clear directions to staff on the level of assistance the person needed or what should be done to reduce the risk of falls.

The care plan stated clearly that the person should be encouraged to take fluids up to 1500 ml a day but there was no system set up to monitor this.There were no food or fluid intake charts on the file although the deputy manager told us that they should have been in place.

It was clear from looking at daily records that the person due to confusion, did not understand why staff were offering assistance with personal care and this led to them being described as ' aggressive and angry'. There was no evidence that the person had

been referred to an appropriate mental health professional although the deputy manager told us that people were referred to a specialist assessment when they were confused or aggressive they agreed that this had not been done for this resident.

The fifth care plan looked at contained a long-term assessment dated 30 August 2009 that stated that the person would need to see the chiropodist every six weeks. However, there was no care plan related to foot care and the persons toenails were seen to be very long and appeared to need cutting. The deputy manager told us that the chiropodist had seen the resident on 7th December 2009 although this could not be verified in the visitor record signing in book.

The daily record on 31st December stated that the person was 'very aggressive'. However, there was no risk assessment in place in relation to this to give advice and guidance to staff . There was also no evidence that the person had been referred to an appropriate mental health professional to obtain professional guidance in relation to meeting their mental health needs.

Daily records were in place on all care files looked at but the quality of the reporting varied. Some entries were very brief i.e.' no problems' in most entries and did not reflect the persons well or ill being but were lists of tasks undertaken by staff. Some entries were inappropriate including describing a person as being ' difficult' and also one entry in a care plan that advised staff to make sure that the person ' was not wet in the bum'. This does not afford residents dignity or respect in the way they are cared for.

We saw three residents whose feet appeared in poor condition and whose toe nails needed attention. Although the deputy manager told us that the chiropodist had been, they could not provide any evidence of which residents had been see and none of the residents had a care plan relating to foot care.

We spoke to one resident who told us that staff were 'caring' and that the food had improved since the new cook had started work. However, they also told us that 'staff are forgetful and get distracted' and that when breakfast and other meals are delivered to rooms sometimes things were missing.

The hot water temperature in sinks and bathrooms remains very high (between 58 and 60 degrees Centigrade) and presents a significant risk of serious scalding and burns to residents and staff. The deputy manager told us that a contractor had been approached to undertake the work of fitting regulating valves but was unsure when this work would begin.

The deputy manager showed us risk assessments that had been set up for all residents in relation to the hot water temperature. The assessment said that all residents must be accompanied to use the communal toilets and bathrooms to reduce their risk of them scalding themselves. However, it also stated that it 'is individuals choice if service users choose to be left alone when bathing'. The risk assessment is inadequate, contradictory and does not include clear guidance to staff on how to keep people safe from the risk presented by the hot water. The deputy manager told us that they had not been given any training in how to do risk assessments.

We looked around the home and found that there were still no foot operated bins in the communal bathrooms to reduce the risk of cross infection. One area of the home on the

first floor smelt very unpleasant.

One private room and bathroom looked at was very dirty. The bathroom floor and metal toilet frame were dirty with bodily fluids clearly evident. The sink was dirty and the hand towel filthy. Wound dressing were stored in the bathroom and there was a clear risk of cross infection due to very poor hygiene standards. In the bedroom food was stored and there was an open commode pot half full of urine under the bed .

The bed in one private room had been made but the sheets were clearly stained and should have been changed. The frequency of bed changes was not what we expected to see. On one file checked the bed linen had not been changed for thirteen days.

The shower room did not have any signage on it to tell residents where it was and a light bulb was missing.

We observed that a number of windows throughout the home are not restricted but risk assessments in relation to this were not in place. During this visit the temperature throughout the home was very hot. All the radiators had been covered but the cover included the control setting and the temperature of the radiator could not be controlled by staff or residents in their private room. We went into one residents room and noted that it was very hot.The resident told us that the room was 'too warm' and that a window had been opened by a member of staff at their request. The majority of windows in the room were locked and could not be opened.

We noted cobwebs in some window recesses and the back of doors were dirty in the lounge, dining room and some private rooms. We noted that one residents door to their private room did not close, although it was a fire door. This was brought to the attention of the deputy manager. We also noted in this room that out of date medications including creams, ointments and dressings were kept in the bathroom, alongside dental tablets for which there was no risk assessment in place.

We saw that information about all residents and who was their key worker was on a noticeboard for all visitors to the home to see. This breaches confidentiality and this information should not be on public view.

What the care home does well:

It was clear that the deputy manager had worked hard to develop care plans for the two people who at the time of the last visit on the 15th December 2009 did not have any care plans or risk assessments in place. Both care plans have been signed by the residents concerned to indicate their agreement with the care being provided.

The registered provider is now spending more time at the home supporting the deputy manager in the day to day running of the home.

Residents spoken to were generally pleased with the service they received at Shire House. One commented that 'staff do everything we need'.

What they could do better:

All care planning documentation should be fully completed dated and signed. Full

information about the Waterlow (pressure sore) and MUST (nutritional) risk assessment tools should be obtained to make sure that staff have information and guidance on what to do with the assessment outcomes.

The dependency assessment must be completed for all residents so that the home is aware of peoples current care, social and health needs and can put in place measures to make sure that these are met.

Urgent measures must be put in place to ensure that all residents have an appropriate foot care care plan and have access to a chiropodist frequently enough to maintain healthy feet.

The daily record's should be more detailed, person centred and give a clear picture of the persons well or ill being and should not just be a record of tasks undertaken by staff. Consideration should be given to the way in which some daily records and care plans are written to make sure that they do not contain staffs subjective opinion or indicate that people are not referred to in a dignified manner.

Serious consideration should be given how to provide meaningful activities to people who are frail, or who are unable or unwilling to leave their private rooms.

Significant efforts need to be made to improve the cleanliness of the home to make sure that people live in a pleasant environment and that the risk of cross infection to residents and staff is reduced. Efforts must be made to reduce the unpleasant odours on the first floor.

Significant efforts need to be made to improve infection control practice, including the provision of foot operated bins to reduce the risk of cross infection. Beds should not be remade with stained sheets to reduce the risk of cross infection and to afford people dignity.

Consideration should be given to providing signage on the communal shower / toilet to increase the opportunities for residents to retain their independence when moving around the home. Light fittings should always contain a working light bulb to make sure that people can see if they use the facilities at night. Risk assessments in relation to the very high water temperature must be reviewed to make them more robust.

Risk assessments must be in place in relation to the windows that are unrestricted to ensure people are not at risk of harm. The storage of dental tablets in the rooms of residents who have dementia or may be confused should be risk assessed to make sure people are safe from the risk of ingestion.

All accidents that occur to residents must be recorded and the accident book should be checked by the deputy manager and an evaluation of accidents undertaken at least monthly.

This report should be read in conjunction with the key inspection report which gives more detail of the findings of the visit that took place on 15th of December 2009.

If you want to know what action the person responsible for this care home is taking

following this report, you can contact them using the details set out on page 2.

Are there any outstanding requirements from the last inspection?				
	Yes	☑	No	☐

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	The registered manager must ensure that those staff carrying out initial assessments the assessor has had the necessary training to interprete the results of the assessment tools used. To ensure that peoples needs are met and they are not at risk of harm	15/01/2010
2	3	14	The registered manager must ensure that all people who are to reside at the home have their needs assessed. To ensure that peoples needs are met and they are not at risk of harm	15/01/2010
3	7	15	The registered manager must ensure that all care plans and reviews accurately reflect the needs of the person and give enough detail to guide and inform staff as to how to met the agreed needs (Previous timescale of 17/07/2009 and 15th January 2010 not met).	17/07/2009

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
			Not looked at during this inspection.	
4	7	15	The registered manager must ensure that people are consulted with regards the contents of their care plans To ensure that peoples needs are met in a way that suits the individual	15/01/2010
5	9	13	The registered manager must ensure that the receiving, administration, recording of and returning of medication is carried out in accordance with the National Pharmaceutical Guidence so as not to put people at risk of harm. To ensure that people are not put at risk	15/01/2010
6	9	13	The registered manager must ensure that the receiving, administration, recording of and returning of medication is carried out in accordance with the National Pharmaceutical requirements so as not to put people at risk of harm. (Previous timescale of 07/07/2009 and 15/01/2010 not met)	07/07/2009
7	26	13	The registered manager must ensure that infection control policies are adhered	07/07/2009

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
			too so as to promote the well being of those at the home. (Previous timescale of 07/07/2009 not met).	
8	29	19	The registered manager must ensure that your recruitment systems demonstrate that you are satisfied that all staff members are appropriately and safely recruited. To ensure the protection of those who live at the home	26/01/2010
9	29	19	The registered manager must ensure that any prospective staff member has their fitness to work with vulnerable people established in order to protect those who live at the home. (Previous timescale of 07/07/2009 and 24/01/2010 not met).	07/07/2009
10	30	18	The registered manager must ensure that all staff under a formal recorded induction into the work they are going to perform to ensure people are not put at risk (Previous timescale of 17/07/2009 not met).	17/07/2009
11	30	18	The registered manager	01/08/2009

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
			must ensure that all staff have the necessary statutory training to ensure that peoples needs can be met in a safe manner. (Previous timescale of 01/08/2009 not met).	
12	37	13	The registered manager must ensure that all accidents are recorded and evaluated to maintain the safety of those who live at the home. (Previous timescale of 07/07/2009 not met). Not looked at during this inspection.	07/07/2009
13	38	38	The registered manager must ensure that the hot water temperature does not poise a significant risk of injury. (Previous timescale of 18/06/2009 and 15/12/2009 not met).	18/06/2009
14	38	13	The registered manager must ensure that all risk assessments demonstrate how the safety of the people who use the service or work at the home is being maintained. (Previous timescale of	17/07/2009

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
			17/07/2009 not met). Not looked at during this inspection.	

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	The registered person must ensure that all people who are to reside at the home have their needs assessed. Not looked at during this inspection. Previous timescale 15/01/2010 To ensure that people's needs are fully assessed and the home is confident that they can be met.	02/03/2010
2	3	14	The registered person must ensure that staff carrying out pre-admission assessment has had the necessary training to interpret the results of the assessment. Not looked at during this inspection. Previous timescale 15/01/2010 To ensure that people's needs are appropriately	02/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			assessed.	
3	7	14	The registered person shall ensure that the assessment of the service users needs is kept under review and revised at anytime when it is necessary to do so having regard to any change of circumstances. This refers to care plans and risk assessments. To ensure that records reflect people's current needs and staff have accurate information to be able to meet people's needs.	02/03/2010
4	8	13	The registered person shall make arrangements for service users to receive where necessary, treatment, advice and other services from any health care professional. To ensure that all service users have access to timely chiropody services.	02/03/2010
5	12	16	The registered provider must ensure that there are opportunities for all residents to be involved in meaningful activities based on people's assessed needs and aspirations. (Previous timescale of 12/02/2010 not met). To ensure the well-being of	30/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			the people who live at home.	
6	15	13	The registered person must ensure that all unnecessary risks to residents are identified and as far as possible eliminated. This refers to staff, inclduign catering staff having sufficient knowledge about food allergies and how to keep people safe.	02/03/2010
7	15	18	The registered person must ensure that the catering staff receive training appropriate to their role to ensure that they are able to meet residents assessed needs. To ensure peoples nutritional needs are met and cooks are aware of how to provide specialist diets.	30/03/2010
8	19	13	The registered person must consult with environmental health officers and take action if required shall ensure that it meets the current regulations governing the use of passenger lifts. Not looked at during this inspection. Previous timescale 05/02/2010 To ensure that those who lived at the home are safe from harm.	02/03/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
9	19	13	The registered person must ensure that all windows that are unrestricted in their opening do not pose a significant risk of harm to service users and risk assessed. To ensure that people are not at risk of harm.	02/03/2010
10	19	13	The registered person must ensure that the hot water temperature does not pose a significant risk of harm to those who use the service. Immediate requirement given on 27 December 2010 (Previous time scale of 01/02/2010 not met). To ensure that people who live and work in the home are not at risk of harm.	02/03/2010
11	26	16	The registered person shall keep the home free from offensive odours. To ensure that residents live in a pleasant environment.	02/03/2010
12	29	19	The registered person must ensure that recruitment systems demonstrate that staff have been appropriately and safely recruited. Not looked at during this inspection.	18/02/2010

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			Previous timescale of 26/01/2010 To ensure the safety of those who live in the home.	
13	31	7	The registered person must undergo training to ensure that they have the necessary skills to continue to be responsible for the care home. Not looked out during this inspection. In order to support and promote good practice at the home. You have	01/04/2010

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	7	Urgent consideration should be given to developing a care plan relating to foot care for all residents.
2	7	All care planning documentation , including risk assessments should be fully completed, dated and signed.
3	8	Risk assessments should be in place in relation to the use and storage of dental tablets.
4	8	Full information should be obtained in relation to the use of the Waterlow (pressure sore) and MUST (nutritional) risk assessment tools. This should include all the relevant guidance and give clear instruction and guidance to staff on what to do with the assessment outcome.
5	18	The registered person should give urgent consideration to ensuring that all staff have specific training in relation to

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
		the vulnerable adults. Not looked at during this visit.
6	19	Serious consideration should be given to providing signage for the shower room. The light bulb should be replaced.
7	24	Beds should not be made with stained sheets. Bed linen should be changed at least weekly.
8	25	All radiator temperatures should be able to be adjusted individually and covers fitted should accommodate this.
9	27	The registered person needs to consider if there are sufficient numbers of staff available at lunchtime to meet the needs of those who live in the home. Not look at doing this inspection.
10	38	The accident book should be checked and signed by the deputy manager and evaluated to identify any trends to enable measures to be put in place to reduce accidents.

Reader Information

Document Purpose:	Inspection Report
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Audience:	General Public
Further copies from:	0870 240 7535 (telephone order line)

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