Review of compliance

Shipley Hall Limited Shipley Hall Nursing Home	
Region:	East Midlands
Location address:	The Field Shipley Heanor Derbyshire DE75 7JH
Type of service:	Care home service with nursing
Date of Publication:	July 2011
Overview of the service:	Shipley Hall Nursing home provides accommodation for up to 30 older people who require nursing or personal care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Shipley Hall Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us they had been involved in their care plans and that they were happy with the support they received from the staff team.

People told us that they felt there was enough staff on duty to support them. Comments regarding the staff team were positive. One person said, " they're very friendly and always available if you need them"

People told us that the meals provided were enjoyed. They said that there was plenty of variety and choice.

People told us that activities were available if they wanted to join in this included sensory therapies, arts and crafts and nail painting. One person told us that they went out on a regular basis both with their family and for local walks with staff support.

People that we spoke to told us that they got on well with the staff. They told us that the staff were friendly and they felt safe at the home

People told us that they would speak to the manager if they had any complaints. One person said "I'm sure they'd sort things out if there was a problem, they're very good" another person said," No complaints, I'm very happy here".

What we found about the standards we reviewed and how well Shipley Hall Nursing Home was meeting them

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

People's capacity to consent to their care and treatment was not clearly recorded.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People using the service were provided with appropriate and coordinated care that met their needs and preferences.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The correct safeguarding procedures and record keeping are not always followed to ensure people using the service are safeguarded from harm

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Quality improvement systems were in place and were being further developed to ensure the quality of services provided to people was effective.

Outcome 17: People should have their complaints listened to and acted on properly

The systems in place did not ensure that complaints were addressed in a timely and considerate manner.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

Peoples safety was compromised as important events that affect the welfare, health and safety of the people using the service were not reported to us under regulation 18 of The Care Quality (Registration) Regulations 2009.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
Some of the people using the service were able to confirm that they had been involved in their care plans and confirmed that they were happy with the support they received from the staff team.

From observations throughout our visit we observed staff supporting people to make choices and decisions. We observed a positive rapport between the staff and the people using the service. Staff supported people in a friendly and respectful way and it was evident that people felt relaxed and comfortable in their environment.

Other evidence
We reviewed the care records of two people. These records demonstrated that people and their representatives were involved in the planning of their care. Signatures of either the individual or their personal representative had signed documents to confirm that they had read and agreed with their plan of care.

There was detailed information in care plans that showed us that people were supported to make decisions and choices in their daily lives and that their independence was respected.

Assessments were not in place to demonstrate that people's capacity regarding

consent to treatment and care had been determined in line with the Mental Health Act. The registered manager told us that capacity assessments had been undertaken for people using the service and stated that these had been archived.

However a previous deprivation of liberty authorisation was in place in one person's care records. This demonstrated that people's rights were taken into consideration to protect their best interests.

Our judgement
People's capacity to consent to their care and treatment was not clearly recorded.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that they felt there was enough staff on duty to support them. Comments regarding the staff team were positive. One person said, " They're very friendly and always available if you need them"

People told us that the meals provided were enjoyed. They said that there was plenty of variety and choice.
Some of the people using the service required a soft diet. The manager confirmed that food moulds were not used to enhance the appearance of meals that were provided.

People told us that activities were available if they wanted to join in. We visited the activity room where people were being supported in various activities.We spoke with the activities coordinator who told us about the types of activities available, this included sensory therapies, arts and crafts and nail painting.

The activities coordiantor was also a hairdresser and provided a hair dressing service at the home on a weekly basis. Many of the people spoken with confirmed that they were booked for a hair appointment on the day of our visit and stated that they looked forward to having their hair done.

One person told us that they went out on a regular basis both with their family and for local walks with staff support.

Other evidence

Needs assessments detailed people's health and social care needs, including their prescribed medication and their preferences and preferred routines.
Care plans were up to date and detailed people's support needs and abilities. This ensured people were supported to maintain their independence whenever possible.

Risk assessments were in place and reviewed on a regular basis which ensured that people were supported in a safe way.

There was evidence of continuity of care with other care providers. Records were seen to demonstrate that health monitoring was in place, such as monthly weight recordings, visits from health care and social care professionals, including medication reviews and psychiatric assessments. Information was also provided to demonstrate that when needs changed the correct advice and support was sought from the relevant specialist services.

Discussion with staff confirmed that training was provided to them on an ongoing basis. The staff files and training matrix showed us that all mandatory training such as Moving and Handling, Fire Safety, Health and Safety, Infection Control, and Safeguarding Adults was provided to staff on an ongoing basis. The registered manager told us that she was in the process of booking staff onto the Mental Capacity Act and Deprivation of Liberty Safeguards training that was provided by the Local Authority. Staff were provided with other training that was specific to the needs of the people using the service, such as dementia awareness and Palliative care

Our judgement
People using the service were provided with appropriate and coordinated care that met their needs and preferences.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People that we spoke to told us that they got on well with the staff. They told us that the staff were friendly and they felt safe at the home. We observed a positive rapport between people using the service and the staff on duty.

Other evidence
There has been one investigation undertaken by Derbyshire Adults Safeguarding Team this year. This incident indicated that the moving and handling procedures used for one person on one occasion had resulted in this person sustaining an injury. The training matrix showed that all of the staff team, other than the registered manager had undertaken Moving and Handling training in 2011 and the majority of staff had received up dated training following this incident. The registered manager confirmed that she was due to undertake an update of this training with Derbyshire County Council.

The provider's safeguarding policy and Derbyshire's Safeguarding policy was in place at the home. Staff spoken with confirmed that they had undertaken training in safeguarding and the training matrix demonstrated that all but seven staff were up to date with this training. Five staff were due an update on this training and two staff had been recently employed. The registered manager confirmed that this training was being booked with Derbyshire County Council.

Written information was seen in one person's records regarding an incident with another person using the service. Although the staff on duty had taken immediate action to protect the person involved and informed the families of both people involved

in the incident, it should have been referred to the local authority under safeguarding procedures. This had not been done. We had not been notified about this incident under regulation 18 of The Care Quality (Registration) Regulations 2009.

Another person had written information in their records regarding an injury that occurred due to an omission of safe practice by a member of staff. Staff had taken immediate action and provided first aid to this person and hospital intervention was not required. This incident constitutes neglect and should have been referred to the local authority under safeguarding procedures but this had not been done. We had not been notified about this incident under regulation 18 of The Care Quality (Registration) Regulations 2009. The registered manager stated that she had addressed this incident with the member of staff involved and further training had been provided. However there were no written records to demonstrate this.

Written information from the provider acknowledged that following our visit they had identified the need to report relevant incidents to the local authority under safeguarding procedures and not just to the family and care manager.The written information stated that all information would be documented and this improvement would involve every member of the care staff team, overseen by the Clinical Lead, Team Leader and Registered Manager.

We saw information in one person's care file that showed us that a deprivation of liberty authorisation had been in place to safeguard them from harm. The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) exists to protect people who cannot make decisions about their care and treatment when they need to be cared for in a particularly restrictive way. Detailed records were held which demonstrated that the home was complying with the required standards regarding The MCA DOLS process. Information within this person's record showed us that this authorisation had now ended following a formal assessment which demonstrated that the controls that had been put in place were no longer required.

Our judgement
The correct safeguarding procedures and record keeping are not always followed to ensure people using the service are safeguarded from harm

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
In April 2011 a residents meeting was held and some people that we spoke with were able to confirm this. The registered manager told us that these meetings would be held every three months.

The registered manager told us that satisfaction questionnaires had been developed but these had not been sent out at the time of our visit.

Reviews for people using the service were undertaken to ensure any changing needs were identified.

Other evidence
We saw written evidence that demonstrated that the quality of the service was reviewed on a continuous basis this included monthly audits regarding medication, infection control, fire safety, maintenance and environmental assessments.

Written information from the provider told us that that they were developing their care plans by using the advance care planning approach which involves the person using the service, their relatives and a multi disciplinary team in order to give them the best care and outcomes of their wishes. Care plans were in place regarding people's future care and advanced statement of wishes.

Written information from the provider told us that following our visit, the provider, registered manager and deputy manager will undertake monthly audits to review

incidents and how they have been managed. It was confirmed that this information will be documented including any actions required.

Our judgement
Quality improvement systems were in place and were being further developed to ensure the quality of services provided to people was effective.

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are minor concerns with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
Some of the people that we spoke with were able to confirm that they didn't have any complaints about the care and services they received. People told us that they would speak to the manager if they did. One person said "I'm sure they'd sort things out if there was a problem, they're very good" another person said," No complaints, I'm very happy here".

Other evidence
In April 2011 we received a copy of a complaint made to the home by the relative of a person who had used the service. At our visit the registered manager told us that the complaint had been investigated but the complainant had not been informed of the outcome of the investigation, although they had initially been informed in writing that their complaint would be investigated.
Following our visit to the service the registered manager has confirmed in writing to the complainant the outcome of their investigation.

Following our visit written information and a telephone discussion with the registered manager acknowledged that the current practice in addressing complaints was not done in a timely and sensitive manner. Their written information stated that all future complaints will be responded to within 7 days and investigated with feedback to the person making the complaint within 14 days. The registered manager also confirmed that future complaints will be fed back in a more considerate way.

A complaints log was in place to record any concerns raised. No other complaints had

been made since the registered manager commenced employment in October 2010.

Our judgement
The systems in place did not ensure that complaints were addressed in a timely and considerate manner.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are moderate concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
People spoken with did not raise any concerns to us regarding any incidents at the home.

Other evidence
As stated in outcome 7, during our visit to the service we identified that there had been two incidents that should have been referred to us under outcome 20 regulation 18. Although the registered manager has confirmed following our visit that all future incidents will be reported to us, our concern is that the registered manager was not aware of this requirement prior to our visit, which compromised the safety of the people using the service.

Our judgement
Peoples safety was compromised as important events that affect the welfare, health and safety of the people using the service were not reported to us under regulation 18 of The Care Quality (Registration) Regulations 2009.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: People'st capacity to consent to their care and treatment was not clearly recorded.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The correct safeguarding procedures and record keeping are not always followed to ensure people using the service are safeguarded from harm	
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 17: Complaints
	How the regulation is not being met: The systems in place did not ensure that complaints were addressed in a timely and considerate manner.	
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met:	

	Peoples safety was compromised as important events that affect the welfare, health and safety of the people using the service were not reported to us under regulation 18 of The Care Quality (Registration) Regulations 2009.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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