Shipston House Ltd

Shipston Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Shipston Lodge is registered to provide accommodation, nursing and personal care for up to 70 older people, including people with dementia. At the time of our visit there were 47 people living at the home.

Shipston Lodge is a purpose-built home with care and support provided across two floors. On both floors there were communal areas, dining areas and lounges, as well as people's bedrooms which were all ensuite. People could access both floors of the home via a lift or staircase. On the ground floor was a bistro area where people could meet each other and where the provider held a weekly dementia café.

People's experience of using this service and what we found
At our last inspection, we found some improvements were required. People had a plan of care that provided guidance to staff in how to support them. Associated health risks were assessed, but these were not always updated and reviewed immediately when a person's needs changed, or where advice was sought to ensure the risks were not increased. Records did not always correspond with a person's specific requirements. The provider completed a range of audits, but we found during this inspection shortfalls in the service had not always been known or considered by the registered manager or provider.

At this inspection, we found the provider had made positive improvements. Since the last inspection, there was a new registered manager who had spent time adding to and increasing the oversight of the service to improve people's outcomes.

Additional audits, checks and daily meetings with clinical staff helped ensure people received the right care and support. Heads of department meetings were held frequently which helped ensure the whole service continued to meet people's needs. New admission information was shared with key staff, so staff were prepared to provide the right care to the person.

Care plans and risks assessments supported people's needs and plans were personalised to individual needs.

People and relatives were complimentary of staff. Staff knew people well and we saw during our visit, staff quickly responded to situations to help promote good care outcomes.

Staff interacted with people at their pace, unrushed and talking to people with familiarity. Staff were involved and engaged, and we saw they had time to sit and chat to people which helped develop relaxed and supportive relationships.

People were safe because staff understood their responsibility to report any concerns to protect people from the risk of abuse.

The provider had their own staff team and had limited or no reliance on agency staff. This meant staff who supported people knew them well. Staff received training in key areas and staff said they felt supported to pursue additional training and opportunities to increase their knowledge and confidence. Competency checks were completed for staff to ensure they supported people safely with medicines.

Infection control systems ensured the home was clean. Housekeeping staff supported the home and staff wore personal protective equipment to help minimise the risk of cross infection. Maintenance and regular environmental checks on health and safety ensured the home remained safe for people.

People's overall feedback to us was positive of a service they received that they felt met their needs. People and relatives could attend meetings to share any feedback about the service. Some people and relatives said when they raised some issues the responses were not always timely. However, the general view was the service had improved since our last inspection with the overall management and staff team.

Families and external health visitors were welcomed and there were no restrictions on visiting arrangements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 July 2021).

Why we inspected
This inspection was prompted by a review of the information we held about this service and to check the provider had improved certain areas identified at our last visit.

This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remained the same. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shipston Lodge on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well led.

Details are in our well led findings below.

Shipston Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection visit was carried out by four inspectors and one Expert by Experience. An Expert by Experience is someone who has experience of using this type of service.

Service and service type
Shipston Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Shipston Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection visit was unannounced.

What we did before inspection
We reviewed the information we held, such as people and relatives' feedback and statutory notifications, as well as any information shared with us by the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people who received a service to get their experiences about the quality of care received. We also spoke with 10 relatives who family members received a service. We spoke with 10 members of care staff that included a nurse, a wellbeing lead, a care practitioner and a deputy manager. We spoke with the registered manager and a chief operating officer, a maintenance person and an administrator. We also spoke with an external professional from the carers trust.

We reviewed a range of records. This included examples of 7 people's care records and samples of medicine records and associated records of their care. We looked at records that related to the management and quality assurance of the service, fire safety and environmental risks and records for infection control and risk management. We also reviewed 2 staff recruitment files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

- At the last visit we found risks associated with people's individual care needs were not consistently assessed, monitored and reviewed.
- At this visit, people had plans which informed staff how to manage any identified risks associated with their health or medical conditions. People's care plans were reviewed regularly and where people's needs had changed their care plans reflected this. For example, 1 person required additional repositioning due to skin damage. The risk assessment and care plan were clear about how regularly this needed to happen to keep the person safe.
- Staff told us people's care records contained the relevant information needed so they could provide safe care. Staff responses matched people's care plan information. One staff member said, "The documentation is really strict and detailed. Everything is live and updated when it happens."
- People were referred to a physiotherapist to support them if they had identified risks around their mobility or movement.
- There were systems to support people in the event of an emergency. Each person had a personal emergency evacuation plan which contained information about how best to support them during an evacuation.
- Regular maintenance work and health and safety checks were completed to ensure the environment remained safe, for example fire safety checks.

Staffing and recruitment

- Overall, there were enough suitably trained and qualified staff to meet the needs of the people living at the home.
- However, some people and relatives told us they thought staffing levels were not always ideal. For example, if they called for assistance, help sometimes took longer than expected.
- Our observations throughout our visit showed staff were on hand and attentive to support people's physical and emotional wellbeing. When care bells rang, these were responded to.
- People told us they received support from a staff team who knew them well. The registered manager and provider regularly reviewed staff numbers on shift to ensure they continued to meet people's assessed needs. If staff were needed, the registered manager said they were put onto the rota. Staff said staffing levels were suitable to meet people's needs.

Using medicines safely

- People received their medicines safely.
- Staff had training in medicines before they administered medicines. Trained staff had competency

assessments to ensure they continued to administer people's medicines safely.
● Medicines were stored safely and securely.
● Where people needed 'as required' (PRN) medicines, there were detailed protocols and risk assessments to ensure they were administered in line with the prescribed instructions.
● Some people had medicines delivered through patches applied to their body. Some patches need alternating sites on the body to reduce the risk of having too much medicine. The medicine administration records (MAR) consistently recorded this information.
● The provider had an electronic medicines system which staff told me had significantly reduced any potential errors.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us they were happy with their care and support and that they felt safe when staff supported them. One person said, "They (staff) look out for me...it's lovely here." Another person said, "Yes, I do feel safe- I've not ever felt unsafe living here. I've got a bolt on my window, I don't feel worried and there are people around, I know that."
● There were systems to safeguard people from abuse. Where concerns were identified the safeguarding authority were notified along with CQC.
● Staff knew what to look for regarding abuse and felt supported to raise any concerns they may have about the people they were supporting.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The registered manager kept updated with government guidance. Visiting was allowed and facilitated. When visiting restrictions were in place, telephone calls and calls over the internet were encouraged and supported so families could maintain contact.

Learning lessons when things go wrong
● Accidents and incidents were recorded in detail with immediate actions taken by staff to ensure people's safety.
● Generally, records documented the events and action taken post incident. However, some incident forms were not always completed consistently with some unexplained omissions in 'contributing factors'.
● Accidents and incidents were reviewed by the registered manager to identify any patterns or trends and to ensure action had been taken to mitigate risk and keep people safe.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At the last inspection we found care records did not always support staff to deliver personalised care. At this visit, we found care plans, important information and staff's knowledge meant people received a personalised service.
- People and relatives said the service was responsive. One relative said, "This place is wonderful- everyone is so helpful and it is a fabulous place". One relative told us their family member had frequent falls. They told us, "When (Person) had a fall we had phone calls straightaway to tell us and explain what they were doing." This relative said, "Sometimes staff even ring us up as late as 10pm with small updates- we are very impressed."
- Another relative said, "We think the home is really on it- when you come here you feel that you are always being looked after and when we leave, we feel that (Person) is being looked after as the number 1."
- Each person had an individualised care plan which contained details of known preferences and important information about the individual which helped staff get to know the person
- Care plans provided a clear explanation of people's individual care and support needs. This included information to support staff with managing any incidents where a person may exhibit anxiety or be at risk of falling.
- Staff we spoke with had a good knowledge of people's changing care needs. Information was shared at daily handover meetings and Heads of Department meetings. However, some information that should have been shared about monitoring a person's ongoing health monitoring was missing. Immediately after the inspection, the chief operating officer confirmed additional actions ensured this information was now captured for staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The standard, frequency and aptness of activities and the promotion of interests and hobbies for people brought differing views. The provider had appointed two new wellbeing staff to support people with activities and interests. Most people gave us positive reactions to their recent impact and effectiveness.
- There were regular activities organized which people attended set out by a weekly planner, but several people said to us they felt there was not enough for them to do. Throughout our visit people listened to music, watched TV or sat in communal areas with others or quietly reading a book.
- Staff used the activity programme to inform people in advance, of any activities they wanted to join in. Sessions included pet therapy, arts and crafts, seated stretch, musical sessions, as well as wordsearches, boardgames and garden walks.

● On the first floor we saw a part of the home was designed as a train carriage, with a video of a train passing through countryside with atmospheric sounds. Staff told us one person liked trains and regularly sat at a table to enjoy this.
● The home had a designated activity room for arts and crafts, quiet areas, a library and a pub for people to enjoy that included a private dining area.
● Important family links were maintained to help keep people and their families connected. Visiting was supported and if families were unable to visit, the use of technology helped families keep in touch over the internet or telephone.
● Local links with the local community were being strengthened. For example, church and pastoral visits took place. Links with local communities helped people keep in touch and make new friendships.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's records included information about how they communicated and guidance for staff in how to communicate effectively with them.
● Staff ensured people had regular checks to ensure their sensory needs were met and they had the appropriate aids available to support their communication. For example, hearing aids, spectacles and support with oral healthcare.
● A member of clinical staff explained how documents could be made available, where required, in accessible formats. They gave an example of a person who used a white board to communicate their wishes and needs.

Improving care quality in response to complaints or concerns
● The provider's complaints policy was on display in the home and included information about how to make a complaint and what people could expect if they raised a concern. This policy signposted people to external organisations where they could share any concerns if they wished to do so.
● Records demonstrated complaints were investigated and responded to and any actions to improve the quality of care identified.
● People and their relatives told us they felt the response to complaints and informal concerns had improved over recent months, but this was not everyone's experience. Some people told us if they raised an issue, they felt it was up to them to find a solution. The registered manager confirmed all complaint and concerns had been responded to.
● People were involved with staff in day-to-day choices so when people's actions or signs showed they were unhappy, staff supported people to prevent any minor concerns escalating.

End of life care and support
● The provider had responsive care planning to support people when they come to the end of their life.
● At the time of our visit, no one was receiving end of life care. The registered manager aimed to support people's wishes to remain at the home for end of life whenever possible, with external healthcare professional support.
● People's care plans included the Recommended Summary Plan for Emergency Care and Treatment form (ReSPECT). This plan provides clinicians with information about whether attempts at resuscitation should be undertaken for the person.
● As people's health declined, discussions were held with them and their relatives to ensure they were able to spend their final days as they wished to, and any spiritual or cultural needs were met. The registered

manager showed us a designated room for families to stay overnight to help family members be together at this important time.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At our last visit we found systems to monitor and ensure improvements were needed were not always effective. There was a lack of oversight of people's individual care needs, so that assurances could be gained that staff were continuing to monitor and review care according to people's needs. At this visit, we found improvements had been made.
- The registered manager strengthened the providers audits and checks. They had introduced heads of department meetings, daily handover meetings and increased the clinical audits. These audits and checks were completed at regular intervals and actions were taken to drive improvement. Actions from completed audits were included on a home improvement plan monitored by the registered manager to ensure actions were taken.
- During our visit, we some improvement to food and fluid charts required better documentation to show what exactly people had consumed. Following our visit, the chief operating officer confirmed improvements and processes had been implemented.
- The registered manager was visible to people and staff and they had a good knowledge of the people and the service. The registered manager said, "If you don't work the floor, you don't know what is going on." The registered manager said the care practitioner role was a new addition following our last inspection which helped support staff and nurses.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider and registered manager encouraged feedback from people, relatives and staff through questionnaires to improve the service people received.
- Staff had regular handovers between shifts to share information about people
- People, relatives and staff were invited to regular meetings where they were updated about any changes in the home and invited to give their feedback about the service.
- The provider had shared the results of the last inspection with staff and sought their suggestions about how to address the areas for improvement identified. Actions taken in response to staff feedback included appointing care practitioners to support the nursing staff.
- However, the majority of people and relatives we spoke with were happy and acknowledged improvements had been made. Most people and relatives complimented the management of the home. Where negative comments were made to us, they were similar in that if concerns were raised, some people felt nothing was done or they felt the onus was put on them to come up with a solution.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

● There were opportunities for the local community to visit and support the home through events to raise funds such as summer and winter fetes.

● The provider had opened a dementia café in the home so they could support people and their families who were living with dementia in the local community. There were also weekly meetings to support unpaid carers within the local area.

● A relative told us about the positive culture that existed in the staff team which made the home welcoming and relaxed. This relative said, "What I particularly like- the staff- there is a whole culture of being bright and helpful and happy". This relative said, "There is a hierarchy but they (staff) are all equal- the maintenance man who is lovely, the chef – they are all involved and clearly all part of the team."

Working in partnership with others

● The registered manager was establishing better working relationships with other healthcare professionals to improve outcomes for people.

● Staff worked with healthcare professionals to make sure people's health needs were met. We saw evidence in people's records that referrals had been made in a timely way.

● The home had links with a national charity to raise funds for the local community.

● The chief operating officer told us they were hosting a Christmas market at the home where people, families and the local community could come together to celebrate Christmas.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibility to be open and honest when things had gone wrong. Relatives told us that any issues regarding the care of people, or incidents were openly discussed with them.

● The provider had met the legal requirements to display the services latest CQC ratings in the home.

● The registered manager and provider responded positively to our visit and took immediate steps to address the issues we raised at the time of our visit.