Shelley Park Limited

Shelley Park

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Shelley Park is a specialist nursing home providing accommodation, care and treatment for up to 43 adults with complex needs including neurological conditions and physical disabilities. They provide care for people with the following needs:

- Acquired Brain Injury
- Traumatic Brain Injury
- Neurological Conditions
- Progressive Degenerative Conditions
- Physical Disability
- Learning Disability
- Behavioural Impairment
- Complex Nursing Care Needs

They offer a range of services including domiciliary care services, specialist multi-disciplinary assessment services, respite care and long term care for people with enduring conditions. People's treatment is managed through three pathways of care: acquired/traumatic conditions, transitional (for people working towards greater independence) and enduring/complex or end of life care.

The home is comprised of three buildings:

- Florence House, which can accommodate 37 people on pathways of care for acquired/traumatic and enduring/complex or end of life care.
- Westby House, which can accommodate six people on the transitional pathway; four people in transitional living units with shared facilities and two independent flats where people can prepare for moving on to independent living.
- Shelley House, main reception 'hub' for the service where day care and therapy services are based.

The home was last inspected in January 2014 when it was found to be meeting all the required standards.

There was a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Overall, people were very positive and complimentary about the staff team and the way they cared for and supported people.

People felt safe living at the home and there were comprehensive systems to make sure that the environment and the way people were cared for and treated were safe.

Staff had been trained in safeguarding adults and were knowledgeable about the types of abuse and how to take action if they had concerns.

Accidents and incidents were monitored to look for any trends where action could be taken to reduce likelihood of their recurrence.

The service employed a multidisciplinary team and there were sufficient staff to meet the needs of people accommodated.

Recruitment procedures were being followed to make sure that suitable, qualified staff were employed at the home.

Medicines were managed safely and administered by trained staff.

The staff team were both knowledgeable and informed about people's care and treatment needs. There were good communication systems in place to make sure that different professionals involved in people's care were kept up to date and worked to agreed overall objectives.

Staff were well-supported through supervision sessions with a line manager, an annual performance review and also direct supervision or external peer supervision.

Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and acted in people's best interests where people lacked capacity to make specific decisions. People were consulted and gave consent to the care and treatment where they were able.

The home was compliant with the Deprivation of Liberty Safeguards with appropriate applications being made to the local authority.

People were provided with a good standard of food and their nutritional needs met.

People's care needs had been thoroughly assessed. Comprehensive and detailed care plans had been developed to inform staff of how to care for people. The plans were person centred, covered all areas of people's needs and were up to date and accurate.

People and staff were very positive about the standards of care provided at the home. People were treated compassionately as individuals with staff knowing people's needs.

People were involved in planning a programme of individualised activities to keep them meaningfully occupied and as part of their rehabilitation.

There were complaint systems in place and people were aware of how to make a complaint.

Should people need to transfer to another service, systems were in place to make sure that important information would be passed on so that people could experience continuity of care.

The home was well-led. There was a very positive, open culture in the home with staff proud of how they supported people.

There were systems in place to audit and monitor the quality of service provided to people.

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

People were protected from avoidable harm and abuse.

Staff were trained to prevent, recognise and report abuse.

Staff were recruited safely because full pre-employment checks were carried out and references were obtained.

Medicines were managed safely and staff competence was checked.

Is the service effective?

Good

Staff received induction and on-going training to ensure that they were competent and could meet people's needs effectively.

Supervision processes were in place to monitor performance and provide support and additional training if required.

People were supported to have access to healthcare as necessary.

People were supported to eat and drink appropriately.

Is the service caring?

Good

People had good relationships with staff.

We observed that staff treated people with warmth and compassion.

Staff respected people's choices and supported them to maintain their privacy and dignity.

Is the service responsive?

Good

People's needs were thoroughly assessed. Care and treatment was planned and delivered through multidisciplinary working to meet their needs.

People had individualised activities programmes to aid their rehabilitation and keep them meaningfully employed.

The service had a complaints policy and complaints were responded to appropriately.

Is the service well-led?

Good

There was a clear management structure in place. People and staff told us that the management team were approachable and supportive and they felt they were listened to.

Feedback was regularly sought from people and actions were taken in response to any issues raised.

There were systems in place to monitor and assess the quality and safety of the service provided.

Shelley Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection that took place on 8 and 13 June 2016. The inspection was unannounced and carried out by an inspection team of an inspector and a specialist advisor on the first day and one inspector on the second day.

The provider had not completed a Provider Information Return (PIR) as this form had not been requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the notifications we had been sent from the service since we carried out our last inspection. A notification is information about important events which the service is required to send us by law.

We also liaised with the local social services department and received feedback about the service.

During the course of the inspection we case tracked the care of five people. This involved speaking with the person, looking at their care records and speaking with staff.

We spoke with eight people about the care and treatment they received. We were also able to observe interactions between staff and residents and attended part of a music therapy session with a group of people.

During the inspection we were assisted by the registered manager and spoke with:
- the registered manager
- the Nominated Individual for the company and the operations director
- the clinical lead, rehabilitation lead and service development lead for the home
- a music therapist and an occupational therapist

- the care co-ordinator
- two registered nurses
- two health care assistants

We looked at records relating to the management of the service including; staff recruitment records, staffing rotas, incident and accident records, training records, records relating to complaints, minutes of various meetings and medicine administration records.

Good

Is the service safe?

Our findings

Everyone we spoke with had positive things to say about the home and the service they received. No one raised any safety concerns.

People were protected from bullying, harassment and avoidable harm because staff had completed training in adult safeguarding that included knowledge about the types of abuse and how to refer allegations. Training records confirmed staff had completed their adult safeguarding training courses and received refresher training when required.

The staff we spoke with were aware of the provider's policy for safeguarding people. Information posters about adult safeguarding were also displayed around the home, providing prompts for staff on the procedures that should be followed.

The registered manager had well developed systems in place through risk assessment procedures and processes and this ensured people's safety.

Within people's care records was a risk assessment of their room and environment. This identified any hazards and steps taken to minimise the risks to that person. For example, thermostatic mixer valves were fitted to hot water outlets to make sure hot water temperatures were safe and freestanding wardrobes attached to the walls if there was a risk they could be pulled over. Radiators had been covered to protect people from the risk of burning themselves on hot surfaces.

On the first day of the inspection a member of staff showed us around the premises and we did not identify any hazards.

The registered manager had employed external contractors to make sure portable electrical equipment was safe, the water systems safe with regards to Legionnaires' disease and the building safe concerning asbestos. The fire safety system was tested and inspected to the required timescales and certificates showed that the hoist, lift and boilers were also tested at the required times. A comprehensive fire risk assessment had also been carried out.

Staff told us that maintenance issues were always attended to straight away.

As well as these systems to make sure the physical environment was safe for people, there were systems to make sure care and treatment was delivered as safely as possible. Risk assessments were on file for the people whose records we looked at. These included assessments concerning malnutrition, prevention of falls, people's mobility and skin care. Other examples included, a shower protocol that was in place to make sure a person's wish for privacy was respected whilst making sure that they were safe when showering and where people had bedrails used to prevent their falling from bed. Risk assessments underpinned people's care plans to make sure that their care and treatment was delivered as safely as possible.

Personal evacuation plans were in place for everyone to make sure they could be safely evacuated in the event of a fire.

Systems were in place to reduce the likelihood of accidents recurring through the monitoring of any accidents and incidents that had occurred in the home. The registered manager reviewed all accidents or incidents and recorded any action taken. We saw, for example; a person had been referred to the falls clinic after a fall, a care plan reviewed for when taking a person out into the community who had epilepsy and a behaviour care plan put in place for a person to assist with personal care needs. Accidents and incidents were also periodically reviewed to look for any trend where action could be taken to reduce the incidence of recurrence.

Shelley Park employed a team of people from a range of disciplines including; care assistants and nursing staff, chefs and kitchen staff, laundry and domestic staff, occupational therapists and physiotherapists, speech and language therapists, psychologists, a music therapist, an art teacher and administrative staff. We found all professionals worked together as a multidisciplinary team to meet people's needs. People and staff we spoke with felt the levels care staff and nursing staff were appropriate. One member of staff commented, "The levels of staffing are much better than my previous experience of working in care homes". People also told us that support was always available from within the staff team as a whole.

Staff recruitment procedures were robust and had been followed. All the required checks had been carried out and required records were in place. These included a photograph of the staff member, proof of their identity, two written references, a health declaration and a full employment history with gaps explained and reasons given for ceasing work when working in care. A check had also been made with the Disclosure and Barring Service to make sure staff were suitable to work with people in a care setting.

People's medicines were managed safely. Two registered nurses took responsibility for ordering people's medicines. One registered nurse had responsibility for the ground floor of Florence House and Westby House, whilst the other registered nurse had responsibility for the middle and upstairs floor of Florence House and the auditing of medicines.

Auditing of medication administration records (MARs) was carried out monthly and evidence was seen of this. Any excess stock was in secure locked cupboards in a locked room. In the MAR charts there was a sample of staff signatures of staff trained to administer medicines, a photograph of the person and an additional photograph on each unit dosage tray of medication for each person. There was also clear information about allergies affecting people at the front of the MAR folder and a photograph of the person concerned. The MAR chart showed the route of administration and a photograph of the tablet or product. The MAR charts showed that people received the medicines they had been prescribed by their doctor.

There was a system for disposal of medications with two nurses signing when drugs were disposed of. Five people were having medicines administered covertly. We saw that appropriate guidelines were being followed, such as a capacity assessment, evidence of pharmacist instructions and authorisation by a GP. For people who were PEG fed, the GP had written in the notes that the tablets could be crushed.

All the registered nurses had been training in the use of emergency administration of medicines in the event of a person having a seizure. One of the nurses had received specialist training for immunisation and anaphylaxis so that they could give flu immunisation and could access adrenalin in case of emergency.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to make sure people received care and treatment they were in need of. A member of staff told us, "We are supported with a lot of training". They said that as well as core training, they had opportunity to pursue more specialist training courses. For example, there was yearly training in Huntingdon's Disease, epilepsy and dysphagia. Care assistants told us that core training included; food safety, fire safety, safeguarding of adults, dementia awareness, moving and handling, the Mental Capacity Act 2005, infection control and health and safety training. Training records showed that there was effective management oversight to ensure people received this training.

New members of staff received induction training that included shadow working with more experienced staff. They were also enrolled on the Care Certificate, which is the recognised induction standard.

All the staff we spoke with said they felt supported, through both formal supervision of meeting with a line manager and from informal support from colleagues within the multidisciplinary team. A member of staff told us, "Sometimes when somebody is admitted with an upsetting history, we ensure there is peer support." Records showed that staff received regular one to one supervision and an annual appraisal from a nominated person. People from professional disciplines could also receive clinical supervision from outside of the organisation. Generally, we found there was positive morale amongst the whole team and everyone we spoke with.

People's consent to care and treatment was sought, in line with legislation and guidance. Some people had capacity to make decisions for all aspects of their lives and people we spoke with told us that their consent was always sought. However, other people did not have capacity to make some specific decisions and therefore were subject to the requirements of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 be 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Mental capacity assessments were in place on people's files concerning specific decisions about their care and treatment. Where best interest decisions had been reached there was clear evidence recorded of the people involved and how the decisions were the least restrictive. We also found that where people had been deprived of their liberty, applications had been made to the local authority. There was also a system to monitor whether applications had been granted and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of the need to establish whether relatives had been granted any lasting powers of attorney so that staff knew about legal authority for decision making where people lacked capacity.

Staff had good knowledge and understanding of the MCA as they had received training in this area.

People living in Florence House had all their meals provided, whereas people living in Westby House were involved in budgeting and cooking their own meals as part of their rehabilitation. People we spoke with in Florence House were generally positive about the standard of food provided. One person told us, "The food is fairly basic but it is good." Another person told us that the chef was aware of all their likes and dislikes and made sure they were provided with meals that they liked. The registered manager told us that on some days there were up to eight choices of meal available to people. In Florence House about a third of people were being PEG fed, (a procedure where people are fed by means of a flexible tube through the abdominal wall into the stomach), because of swallowing difficulties. Nursing staff had all received training in this field and were aware of people's support needs. Other people in Florence House, after assessment from the speech and language therapist, had safe swallow plans in place because of swallowing difficulties. All the staff were aware of people with these needs and there were systems to make sure that people who, for example had their drinks thickened, were not put at risk of choking.

Within people's care plans there was information about people's dietary needs and their likes and dislikes and a record of people's weight and nutritional risk assessments.

People's health care needs were monitored and appropriate action taken if required. Each person was registered with a GP and arrangements were in place for people to receive chiropody, dentistry and other health care services.

Good

Is the service caring?

Our findings

People told us that the staff were all very kind and compassionate.

Staff demonstrated a clear commitment to the people in the care of Shelley Park and their wellbeing. Several staff told us about how the service was caring. One staff member told us "This is such a caring place. The whole team is motivated and works so well together". We observed that staff were caring during the interactions between staff and people.

Staff were patient when speaking with people and were aware of their role in promoting privacy and people's dignity. People had a lock on their bedroom door to help maintain their privacy and dignity. People we spoke with told us that staff would knock on their door before entering.

Staff's awareness to support people's privacy was illustrated when a member of staff took us to meet a person and introduced us. The staff member assisted us in making the person comfortable in speaking with an inspector before withdrawing to let the person speak on their own. We saw an example in a person's care plan whereby the person's wish for privacy with personal care was respected whilst maintaining their safety. Overall, the staff were respectful when interacting with people, addressing them appropriately by their preferred form of address.

Although we did not have opportunity to speak with any family members we were told about how the service worked with families and friends who may also experience difficulties with the 'perceived' loss of the person they used to know.

Good

Is the service responsive?

Our findings

People received highly personalised care that was responsive to their needs and they were satisfied with the service being provided. One person said, "The staff are excellent and they all deserve a medal."

People's needs had been assessed before they were accepted for a placement at the home to make sure that these could be met.

Once people were admitted to the home, staff carried out further assessments and risk assessments to establish a person's needs. These were then used to develop an individual care plan for each person in conjunction with speaking to the person and/or their relatives.

The care plans we looked at were comprehensive, reflecting the multiple and complex needs of the majority of people admitted to the home and the number of different disciplines involved in their care. The example below, of one person who had been admitted to Shelley Park following cardiac arrest, typified the approach and care provided at the home.

The person had been admitted unable to communicate, required PEG feeding, full nursing care and intervention from a range of professionals.

There was a repositioning plan that not only gave an excellent detailed description of how to re-position the person, but also provided clear photographs showing exactly how the person should be made comfortable, for upper body, lower body and seating. In the daily notes the re-positioning chart was signed by the care worker and the supervising registered nurse. A hygiene chart detailed all care that was being provided including the person's PEG feed.

There was intervention from the physiotherapist and a rehabilitation consultant to improve the person's mobility.

There was a very detailed and personalised care plan concerning the person's communication. This identified the following risks:

- risk of social isolation due to reduced ability to communicate effectively
- risk of not being able to communicate acute needs, distress, pain and if feeling unwell
- risk of not being fully aware of the care that was planned for them.

There were then clear interventions of how the staff should address these risks to meet the person's needs. There was also a comprehensive personalised communication book, which included: 'What you need to know', 'I can communicate by', 'How you can help', 'Social history', 'Friends', 'What I like', 'More about me'.

Staff had comprehensively considered the impact of this person's communication needs upon their wellbeing and provided information on their needs, and interests to enable them to fully meet this person's needs.

The psychology team were working with the person to establish if they had 'Locked In Syndrome'. Specialist computer software was being used which, when the person focussed on an object on one part of the screen, would change the screen if they were able to focus. Video footage showed that the person had some level of understanding and eye movement which the team were hoping could be extended to enable the person to turn on and off equipment, such as switch lights, through eye movement. This would give the person greater control over choices and their daily living.

We saw that for another individual, who had progressed to Westby House, this technology and equipment was utilised in their room to allow them to take more control of their life.

We saw that for another person who was cared for in bed and who had a particular interest; their room had been decorated with pictures and objects they would like so that they had a good view of these from their bed.

People had been provided with specialist equipment, such as an air mattress, where this was required. In the case of air mattresses, there was a system to make sure the mattress setting corresponded to the person's weight. People who required the use of a hoist for their moving and handling needs had their own sling to minimise risk of cross infection. As described above, people had very detailed care plans in place to address their moving and handling needs.

People in Westby House had their own individualised care plan setting out achievable goals in supporting them to become more independent.

People were fully involved in planning their goals. Within people's rooms each person had a diary of daily activities and goals that they had set with their therapist. One person told us about the things that they liked and how they had a structure for their day based on these preferences.

Following brain injury many people experience physiological and emotional issues as they come to terms with changes in their abilities and needs. People's care records therefore provided information about people's lifestyle, routines, likes and dislikes and relationships prior to moving to Shelley Park. This was then used to help people to adapt, and develop coping strategies to deal with the change in their circumstances. When observing staff working with people, we saw that there was an emphasis on supporting and celebrating people's strengths and abilities. The staff were very knowledgeable about people and knew of their histories and goals for the future.

There was an active social programme of daily events which includes regular outings/day trips. People had full, individualised activity programs to help keep them meaningfully occupied. For example, one person's interests were noted as dogs and gardening and this has been reflected in their community integration care plan. A young person told us about how they were able to bring their computer games into the home that they enjoyed.

On the days of our inspection we found people engaged in music therapy and art groups. Some people liked to access the local community to go shopping or visit cafes. Within one person' care records we saw that they had had a short holiday at Butlins. People told us they could choose what activities they wished to take part in.

Staff were knowledgeable about people saying there was good communication through staff handovers between shifts. Each week there was also a multidisciplinary team meeting, focusing on each of the care pathways in turn. The meeting would include the lead nurse, a senior care worker and the person's key

worker if that was possible. By these means, each individual would be reviewed each month by the team as a whole.

A member of staff told us, "What we do really well here is our holistic approach. We support our residents to be who they are, living in a local community and to have meaningful relationships with people important to them." Another member of staff told us that they attended conferences and events concerning brain injury and felt confident that Shelley Park was at the leading edge of working with people with brain injury.

The home was in the process of moving to system of electronic record keeping and was working with the software company to ensure that the system could encapsulate the complexities of the service being provided. Overall, the care plans we looked at were up to date, highly personalised and reflective of people's needs.

Good

Is the service well-led?

Our findings

There was a positive, caring and open culture in the home. Everyone spoke highly of how well the home was run with people and staff having confidence that the management team would listen to and act upon concerns if they arose.

The staff we spoke with all told us that there was good morale with everyone working to clear values in supporting people at the home. The following comments were made by staff. "I love working here and I am proud to work for Shelley Park", "We have good teams and supportive management" and, "There is good dialogue between professionals so that we all work together".

The records we reviewed were accurate and up to date and were readily accessible when asked for.

People and those important to them were able to feed back their views about the home and quality of the service they received. Residents' and relatives' meetings took place providing opportunity for people to hear about developments at the service and to give their views. There were regular meetings for staff, which provided updates on changes happening at the home, shared learning from accidents, incidents and complaints, and covered items raised by staff themselves. In the previous month an employee recognition system had been introduced, whereby eight staff would be nominated each month. This was led by the staff team.

A survey involving people was carried out in 2015 with results collated. Overall, there was positive feedback on the service being provided. A survey involving staff was also carried out in 2015 looking at peer support and how this could be developed.

There were well-developed quality assurance systems in place to monitor the quality of service being delivered and the running of the home. These included weekly and monthly audits and reports of topics such as medication, infection control, accidents, incidents and care planning.

The registered manager had notified the Commission of significant events, such as deaths, serious injuries and applications to deprive people of their liberty under the Deprivation of Liberty Safeguards. We use such information to monitor the service and ensure they respond appropriately to keep people safe.