Altogether Care LLP

Winterbourne Steepleton - Steepleton Manor Care Home

Inspection report

Winterbourne Steepleton
Dorchester
Dorset
DT2 9LG

Tel: 01305889316
Website: www.altogethercare.co.uk

Date of inspection visit:
21 September 2016

Date of publication:
05 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Steepleton Manor Care Home was last inspected on17 and 22 July 2015. At that inspection we found that the provider needed to make improvements in the risks people faced and ensuing improvements were made in the way the service developed.

Steepleton Manor Care Home provides accommodation and nursing and personal care for up to 30 older people. There were 18 people living there when we visited.

There was a registered manager in place. 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.'

The provider was meeting the requirements of the Mental Capacity Act 2005. Staff understood some of the concepts of the Act, such as allowing people to make decisions for themselves.

The provider had systems in place to ensure the quality of the service was regularly reviewed but this was not consistently applied which meant that some peoples care records required updating.

Staff lacked guidance with relation to some of the tasks they were required to do. The management did not give staff clear guidance on how to complete some tasks such as close observation of people.

People were not consistently offered choices at mealtimes such as where to sit and what to eat, the system for obtaining peoples choices was ineffective as it failed to take into account some people's memory problems.

Staff told us they felt supported by the management and they felt their opinions were valued.

Staff knew people's needs and the care records generally supported their comments. One person told us "staff help me with washing and dressing, they know my needs and my daily routines. I am well looked after, sometimes they (staff) sit and chat when I go to the lounge". Another person told us " the staff a good to me and never rush, a great place to stay". A relative told us that they felt involved in arrangements made for their loved one.

Staff demonstrated a caring and compassionate approach to people living at the home. People told us there were enough staff to meet their needs, our observations confirmed this.

Staff told us they worked well as a team and enjoyed working at the home.

We found a breache of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The risks people faced were not consistently managed to protect them from harm.

When people had specific guidance to protect people them from harm these were not consistently followed by staff.

Medicines were stored and administered safely but there needed to be a more robust system in ensuring known information in relation to allergies was cross referenced to ensure people were protected from harm.

Staff were clear about who to report safeguarding concerns to but the management had not followed up known information consistently.

Is the service effective?

Good

The service provided was effective.

The Mental Capacity Act (MCA) was understood by staff.

People were provided with sufficient food and drink but improvements in how people were offered choice was required.

Staff attended training updates in order to support their understanding of the needs of the people they cared for.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity, some of the tools designed to promote dignity were not effectively used.

People or those important to people were involved in planning the care and support needs of people living at the home.

Is the service responsive?

Good

The service was responsive. The provider had a system to review

people's support needs and make adjustments to the support given.

People were provided with activities and outings away from the home

The provider had a system for addressing peoples complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The system to ensure the quality of the service was reviewed but improvements made were not effective at driving standards up.

The staff were not well organised to ensure people's needs were met.

Staff confirmed the registered manager was approachable and they felt listened to.

Winterbourne Steepleton - Steepleton Manor Care Home

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 is 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 inspection took place on 20 and 21 October 2016 and was unannounced and was carried out by one inspector.

.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes in the service. At the time of the inspection a Provider Information Record (PIR) 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. Not all the people living at the home could fully explain how they experienced care due to their enduring mental health illness. In order to gain further information about the service we spoke with three people living at the home. We also spoke with seven members of staff and one relative.

We looked around the home and observed care practices throughout the inspection. We looked at five people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments and quality monitoring records.

Observations, where they took place, were from general observations. We also 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.

Before the inspection we spoke with representatives of the local authority's and members of the CCG . These professionals were involved in either the care of people living at the home or their safety.

Requires Improvement

Is the service safe?

Our findings

There was building work being carried out at the time of the inspection. The provider had carried out a risk assessment prior to these works commencing which included steps to reduce the risks such as providing additional staff and ensuring that the door was kept closed unless monitored. We observed on several occasions that tradespeople were entering and leaving the home via a boiler door and that this door was kept open when no staff were in the vicinity. There was a risk that people may access this area without staff support.

We carried out a SOFI during the dinner period in one area of the home. At 1.30, 30 minutes after being supported into the dining room, ,one person was told by staff it was lunch time stating "come on time for lunch, time to wake up". As the person showed signs of wakefulness the staff member walked away to get a chair to sit on, the person appeared to drift back to sleep. The staff member returned and started to support the person with their food but did not tell the person what the food was. The person did not appear to be fully awake and on several occasions coughed and turned their head away when more food was offered. The persons care records identified a risk of choking if the person was not fully awake when eating their food). This put the person at risk of harm.

Staff told us, and records confirmed that they had recently received training in how to protect adults from abuse. We spoke with four members of staff who told us how they would respond to allegations or incidents of abuse. We asked staff how they responded to unexplained bruising (as we had noted one incidents of unexplained bruising in two people's care records). Care staff were clear that they would report it to senior staff who would photograph the area concerned. Senior staff were clear that they would photograph and monitor the persons wellbeing reporting to the registered manager who would investigate the cause to establish if the local authority safeguarding team needed to be consulted.

The registered manager was not available during the inspection. A senior member of staff told us that they had not investigated this but had documented the bruising in the care record. They did not inform us that the issue had been brought to the attention of the registered manager. We did not see evidence to establish if the registered manager had investigated the causes of this or a referral to the local authority safeguarding team had been considered. This meant that the risk of poor or improper care practice had not been fully considered putting people at risk of harm.

The provider had taken action following two people falling in the grounds of the home. Access to the grounds was restricted by a locked fire escape and visual barrier was erected around a particular hazard. The management of the home told us that this was a temporary solution while other options were considered. We raised our concern regarding the locked fire door, which the management considered was acceptable. This was later confirmed as an acceptable interim control measure by the fire and rescue service

The provider had a system to audit medicines received and dispensed in the home but improvements were necessary to cross reference medicines that could cause harm. We noted in one person's care records it was

recorded that they were allergic to Aspirin. However this information was not carried through to the medication records. The provider explained that there was no risk of harm because they would not administer aspirin without a prescription. The other safeguards that were in place were that the GP had noted that the person was allergic to aspirin.

People's medicines were stored, administered and recorded safely. People received their medicines when they needed these and at the required times. The staff responsible for administering medicines had been suitably trained. We observed people receiving their medicines safely and saw staff carry out safety checks, including staying with people while they took their medicines. The medicines were stored in a lockable area and were well organised. The provider had a system to audit medicines received and dispensed in the home.

Three people living at the home told us they felt safe living at Steepleton Mannor. We observed staff interactions with people living at the home and found them to be positive and empathetic. One person told us they did not have concerns about abuse or bullying from staff. One person told us they felt safe living at the home but did raise one concern that they could not always reach the call bell, used to summon staff assistance, as it was a little too far away. They told us that they would ask staff to move it closer to them when they were resting in bed. They told us they felt confident that staff would do this. Another person told us they also felt safe going on to inform us that they "have a whistle to summon help at night, it suits me".

There were enough staff to meet the peoples' needs safely. People told us that there was always enough staff to meet their needs. One person told us " There are enough staff around, they take me out on occasions, if I need help I just ask " another person told us " the girls(staff) stop and ask if I am alright, I like my own company so I stay in my room but I know how to call for help if needed". One person told us they felt it could be short staffed at times but they did not feel it affected them as they were more able than most.

Staff were recruited safely with appropriate checks in place to reduce the chances of employing people who were not suitable to work with vulnerable adults.

Good

Is the service effective?

Our findings

The systems in place to offer choice at mealtimes were not effective for all people living at the home. We spoke with one person who told us "I have a choice at meal times, the staff ask me the day before what I would like, the food is generally good", others who could tell us agreed with this statement. We spoke with staff who confirmed that a choice of meal was offered the day before. We expressed our concerns relating to people with memory problems not being able to make this active choice. The staff told us that they offered people a choice of what's on offer at the time the food is served. We carried out a SOFI during the dinner period in one area of the home. Four people were supported into the dining room at 12.55 a further two people were supported into the dining room 1.10. We observed that three people were served their lunch by 1.20. The staff did not explain what the food was on their plate, did not talk with the people they had served the food too. We did not observe that any of the people in the dining room were offered a choice as described by staff. This meant that the systems in place to offer choice at meal times were not effective.

It is recommended that where people have memory problems, that guidance is obtained with regards to offering effective choice at mealtimes.

Mental capacity assessments were meeting the requirements of the Mental Capacity Act (MCA) 2005. 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 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 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).

The provider had made arrangements for people's capacity to make decisions to be assessed when there were concerns identified. Applications to deprive people of their liberty, Deprivation of Liberty safeguard (DOL's) had been consistently made. The provider had made arrangements for Best Interest Decisions (BID's) to be made and people important to the person had been consulted as appropriate. (A BID is a process where the provider needs to support a person who may not be able to consent to the support due to a lack of capacity)

Staff were aware of the MCA and what that meant for people living at the home. Staff told us about how they offer choices to people who cannot retain information such as offering choices about how they spent their time, to join in activities or what to eat and drink.

We spoke with staff about people's nutritional needs. They told us that currently no one was at risk of unplanned weight loss. Staff told us about the systems they had in place to monitor people's weight to ensure people's care plans could be amended to support their needs as required. People's care records

showed that a recording system was used to monitor what people ate and drank when required

People told us that if they needed to see a health care professional such as a doctor or specialist, staff made the necessary arrangements on their behalf. People gave examples of when they had felt unwell and staff had called the GP 'just in case'. Care records showed that when a person's needs had changed a health care professional had been consulted. We saw evidence in people's care records of health care professional's visits such as tissue viability and diabetic nurses.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs and choices. Staff completed induction training when they first started working at the service. The people we spoke with told us that staff understood their needs and supported them in the way that they wished.

We spoke with staff who told us there was sufficient training available. They told us that they had received ongoing training in many areas such as dementia care, end of life, and person centred care training. We were told training was by external providers and through the providers training suite in Weymouth. The staff confirmed they had regular one to one meetings with a senior member of staff, where they could discuss their role and their training needs. We asked the management to have sight of the recording of these one to one meetings, to confirm they were taking place but they were not available at the time. The provider told us the registered manager keeps these securely but did not know where.

Good

Is the service caring?

Our findings

We noted that when talking with staff they referred to people by their room number rather than their name. We spoke with the provider about this who told us this was to protect people's confidentiality. To refer to people by their room number does not promote dignity and respect.

We observed staff interactions with people living at the home. These in the main were respectful, people appeared to be called by their preferred name and not rushed when offered support. But there were occasions during the observed lunch period where some staff did not communicate with the people they were supporting. Some staff could not identify when people, who could not communicate, were frustrated by their actions such as turning their head away when they did not require further support.

People told us they were well cared for. One person told us "staff help me with washing and dressing, they know my needs and my daily routines. I like to watch TV in the afternoons and go to bed about ten, the staff always come with a cup of tea or a drink and snack, I am well looked after, sometimes they (staff) sit and chat when I go to the lounge". Another person told us "I generally like to stay in my room but that's my choice. The staff know that but still make sure I'm ok throughout the day, staff are good to me and never rush, a great place to stay". One relative told us "My loved one took time to settle, the staff were patient and now things are much better. The staff have taken the time to get to know(name) and I am very pleased with the standard of care being given."

People told us about how staff gained their views about their care needs. One person told us, "sometimes my family and I sit and talk with staff about what help I need". Peoples care records evidenced that reviews of care had been carried out. This demonstrated that people are consulted about their care and support needs. One visiting relative told us about meetings they had with the registered manager and staff before their relative took up residency. They told us they had been asked about their relatives likes and dislikes, what food they liked and how they liked to spend their time. They also told us staff ask if there is anything they feel their relative needs when they visit. they said " staff have taken time to form a good relationship with both their relative and them".

Good

Is the service responsive?

Our findings

The service was not response to peoples changing needs. We looked at one person's care record and looked at the information that was handed over between staff teams when they changed shifts. The care records and daily handover records stated that the person suffered from depression. The daily handover sheets also evidenced that the person had been tearful on two occasions in the past 10 days, but no explanation was recorded. We asked senior staff what the plan of care was to support the person during any depressive periods. One senior staff member told us "it's not really an issue". We asked care staff if the person had depression, one staff member told us "I've never been told that". There was no recorded plan of care to support the person with any mental health illness and the provider had not made any arrangements for the person to receive support from other mental health professionals. This meant that the provider was not responsive to the person's needs.

There was a system to review people's needs. We were told by senior staff that every resident care plan is reviewed each month. On top of this the management audit several care plans each month.

Peoples care records were not always up to date and did not provide staff with sufficient guidance to keep people safe. An example of this was in one person's care record which indicated that they had had a recent 'fit'. The record also indicated that they required assistance to bathe due to mobility issues but did give staff guidance regarding the possibility of a fit in the bath. We spoke with staff who informed us that the person was no longer able to bathe unassisted due to poor mobility issues but did not mention the person may suffer from fits. This meant that the risk assessment required to be updated to reflect the person's current needs.

There were a range of activities available for people. Staff told us about how people chose to spend their time and what activities they enjoyed. An activities coordinator had recently commenced employment at the home The people we spoke with told us about the some of the activities available; some joined in, some did not, although all agreed there were things to do if they wanted to. The staff told us that they had access to a mini bus to enable them to take people into the local community. People told us they had been out to local places of interest. We observed a craft activity that was well attended and appeared to be enjoyed by those participating.

People knew how to make a complaint if they wished to. We looked at the recording of complaints that had been made. Whilst there was some evidence that issues had been addressed in line with the providers complaints policy this was not consistent. We noted that one complaint had been acknowledged but there was no recording of the investigation nor any indicated outcome.

The provider had a complaints procedure which informed people what they needed to do to make a complaint and the time scales for the complaint to be rectified. We looked at the records relating to dissatisfaction about issues at the home. We asked a relative if they had sight of the complaints procedure, they told us they were not sure but felt confident that any issues that they had could be raised with staff and the registered manager. Another relative also told us they were confident that issues could be raised and

addressed informally but they did not have sight or knowledge of the providers compliant procedure.Following the inspection the provider told us that the complaints procedure was displayed in the foyer of the home.

Requires Improvement

Is the service well-led?

Our findings

Improvements were required with the leadership and organisation of staff at the home. A new registered manager was in place but they were not in attendance during the inspection. The improvements, noted at the last inspection, in the leadership at the home had not been sustained.

We looked at the audit of care records carried out by the provider's operations manager. They had identified a number of improvements that were required in the one care record they audited. These included that the person had weight loss which had not been acted upon, consents to treatment had not been signed, risk assessments required updates and a number of inconsistencies in recording. We looked at this care record and found that all of improvements identified had been made. However we looked at a further six care records and found these required similar improvements to ensure that people's needs were being met both effectively and consistently. For example, one person had a recorded weight loss but the nutritional care review did not recognise this, one person who had depression did not have a care plan or guidance to staff to support this person. One person's care records had conflicting advice regarding moving and assisting. The quality auditing system had not identified these issues.

We spoke with senior staff about how the handover of information between different staff shifts was managed. We were told that senior clinical staff gave a verbal handover to staff based on recorded information shared between clinical shift leaders. We looked at the recorded information and found that they were out of date and described people's support needs some time ago. We also noted that some information of significance did not feature in the recorded handover sheets such as a person who had experienced a fit the day before. This meant that there was the potential for confusion about peoples presenting support needs and significant information was not being recorded as handed over, putting people at risk of harm.

The handover sheet identified people who required 'close supervision'. We asked the provider, operations manager and senior member of clinical staff what this meant and how staff achieved this. The responses we received were variable without a firm agreement on what this meant. Following the inspection the provider told us that close supervision would be variable depending on the need of the person and the nurses' evaluation. This meant that staff lacked clear and consistent guidance on how to support people who required 'close supervision'.

We spoke with staff about how their work was organised and allocated throughout key times of the day such as meal times. We noted that an "allocation of tasks" such as bed changes or assistance with a bath were sometimes recorded, but the level of recorded guidance to staff was not consistent. An example of this was that although there was a senior care staff on duty supported by clinical staff, we were told that the first member of staff to finish "doing the people they were allocated to" would start to organise the lunch. We observed the dinner period during the first day of the inspection and considered the staff were not effective managed with people still being served an hour after the lunch period starting.

Records relating to accidents and incidents were not contemporaneous and did not record all of the

concerns identified in peoples care records. An example of this was that we noted that one person had bruising on their upper arms that was not recorded in the accident incident book. Although we asked for a record of the investigation into the unexplained bruising we did not see sight of this during the inspection.

Not all people who lived at the service could tell us how they experienced care. One person who could tell us said" I like being here, the staff are flexible and when I request to do things they always help". Another person also commented that they enjoyed life at the home and there were always things to do. People who could tell us how they experienced support told us they felt they were treated with respect and dignity. However the systems in place to promote people's dignity were not consistently effective. We observed that people had signs hung on their doors the told others not to enter as 'personal care ' was taking place. We noted that in three cases the doors were wide open and the person was laid in bed with no assistance being given. We also noted that in two cases the signs were displayed on people's doors but they were sat in the lounge. We spoke with staff and asked what the signs were for. One staff member told us they are used to promote dignity and let others know not to enter. We pointed out that this was not effective and showed them our observations. They agreed that this should not happen. Therefore one of the systems in place to promote people's dignity were not consistently effective.

The above illustrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the management were approachable and they were given opportunities to influence how the service was run through discussions with staff. Relatives also confirmed that they felt the home was well led and that they could raise concerns with the management if required. They also commented that the registered manager was always available to talk over concerns or just have a chat.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1)(2)(C) Peoples care records were not accurate and failed to provide a contemporaneous record. 17(1)(2)(a)(b)(f) The auditing system in place failed to demonstrate that a robust evaluation of the services provided was driving standards up at the home.