Care Homes UK Ltd

Stockingate Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 12 January 2018 and was unannounced. At the last four inspections the service has been rated as either inadequate or requires improvement. At the last inspection in November 2016 we rated the service as requires improvement. They were in breach of regulations which related to consent to care. At this inspection we found there were still issues around the provider's systems and processes in relation to assessing people's capacity, and progress was limited, although they were no longer in breach of the regulation.

Stockingate Residential Home is registered to provide care for a maximum of 25 people. The manager told us 22 people were using the service when we inspected. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection the service did not have a registered manager although a manager had been appointed and told us they would be applying to register as the manager of Stockingate Residential Home. 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.

We received positive feedback about the manager. The provider carried out a range of checks and audits but these were not always effective. Their systems and processes did not enable them to appropriately assess, monitor and manage quality and safety.

People felt safe but the provider did not have systems in place to safeguard people's finances. Financial records were not robust and people were not provided with lockable facilities. The provider did not always follow safe management of medicine practice. Systems were in place to assess and manage risk to individuals although documentation was not always clear and this could result in risk being inappropriately managed. People lived in a safe and clean environment although one shower was very hot so put people at risk of scalding. The provider took swift action to rectify this.

There were enough staff to meet people's needs and the same workers provided support so consistent care was provided. Recruitment checks were carried out but this was not always done robustly. Staff felt well supported but not all staff had received the agreed number of formal supervision support sessions during 2017. New care workers did not complete the Care Certificate which is a set of standards for social care and health workers.

People told us they were happy living at Stockingate Residential Home and staff were kind and caring. We saw people were treated with kindness. Everyone told us they enjoyed the meals and had pleasant dining experiences. The choice of activities was varied. People had opportunity to engage in group and person centred one to one activities within the service and accessed the local community.

People's care records were person centred and detailed preferences, dislikes, history and what was important to them. However, care plans around management of falls, mobility and management of finances did not always provide sufficient guidance. Staff knew people well. Systems were in place to make sure people's health needs were met.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014: The provider was not managing medicines safely: Staff did not receive appropriate training and supervision: The provider's systems and processes around safeguarding people's finances were not established and operated effectively to prevent abuse of people who used the service. The provider's systems and processes did not enable them to assess, monitor and improve the service. You can see the action we have told the provider to take at the end of this 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 always safe.

The provider had some systems to safeguarding people from abuse but their arrangements for protecting people's finances were not effective.

Medicines were not always managed safely.

There were enough staff to keep people safe. The provider's recruitment process was not always followed robustly.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive training and support which enabled them to do their job well.

Systems around supporting people to make decisions had improved. The provider continued to develop their systems and processes to make sure these were in line with current legislation.

People were comfortable in their surroundings and lived in a pleasant environment.

Is the service caring?

Good

The service was caring.

People who used the service told us they were happy living at Stockingate Residential Home and staff were kind and caring.

People were treated with respect and independence was promoted.

Information was available to help keep people informed about what was happening in the service.

Is the service responsive?

Good

The service was responsive.

The provider's care planning system was person centred and staff usually had guidance so they understood how to deliver appropriate care. Care planning around finances, mobility and prevention of falls were not clear which could lead to care needs being overlooked.

People enjoyed a range of activities within the service and the local community.

People were comfortable raising concerns. A system was in place to record and respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

This was the fifth consecutive inspection where the service had been rated overall as either inadequate or requires improvement.

The provider's quality management systems were not always effective and did not always identify areas where the service had to improve.

People who used the service, relatives and staff felt listened to and had opportunity to share their views.

Stockingate Residential 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.

Before the inspection we reviewed all the information we held about the service including statutory notifications. We contacted relevant agencies such as the local authority, clinical commissioning group and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider had completed a Provider Information Return (PIR) in November 2017. 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.

This inspection took place on 9 and 12 January 2018 and was unannounced. On day one, two adult social care inspectors and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, one adult social care inspector carried out the inspection.

During the visit we looked around the service and observed how people were being care for. We spoke with eight people who used the service, two visiting relatives, four members of staff and the manager. We spent time looking at documents and records that related to people's care and the management of the home. We reviewed four people's care plans.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives told us the care provided was safe. One person said, "I am safe and well looked after." A relative said, "The care is definitely safe, everything is alright." People also told us they were treated fairly and were not discriminated against. One person said, "Everybody is treated the same, it doesn't matter what is wrong with them." Another person said, "As far as I've seen they treat everybody right."

Staff we spoke with told us people were safe. They knew the different types of abuse people might be subject to and discussed the signs that might alert them. They described how they prevented abuse and what they would do if they suspected abuse. They were confident any concerns would be acted on promptly. We reviewed training records which showed 24 out of 26 staff had attended safeguarding training. The manager said the two staff that had not completed training would be doing this imminently, and other staff would be completing safeguarding refresher training.

Information about safeguarding was displayed in the home, which helps ensure people know how to stay safe and report any concerns. In the entrance of the service there was a poster which advised people to contact the home's 'safeguarding champion' if they wanted to find out more about safeguarding and if they were unsure about any issues regarding safeguarding. However, when we spoke with the 'safeguarding champion', who was a senior member of staff, about their role we found their knowledge around safeguarding was limited. We discussed this with the manager who said they would be arranging additional training to ensure the safeguarding champion was equipped to carry out their role proficiently. The manager told us there were no open safeguarding cases at the time of the inspection.

During the inspection no concerns were raised about the safety of people's possessions. However, before the inspection a concern was raised with us that the provider was not safeguarding people's finances. At the inspection we found some people deposited money with the provider for safekeeping. However, the arrangements in place were not robust and did not safeguard people's finances. The provider maintained a 'pocket money sheet' and audit record. These showed reconciliation checks had been carried out to make sure records and monies balanced but there was no evidence that expenditure was explored. Some people had a substantial amount deposited; one person had over £300. We looked at three people's records in detail. The individual balance sheets and monies retained by the provider corresponded.

However, there was a lack of evidence to show how people's monies were being safeguarded. We looked at the three people's care plans and found there was no information about why the provider was controlling their finances and no written agreement about how the money would be managed. We saw records showed people had been given large amounts of money but there was a lack of information to confirm they had received it or would understand how to keep their day to day money safe. In September 2017 one person's record sheet stated '£150' given to [name of person]'. This was not signed by the person and there was no evidence to show the money had been given to the person; there were no receipts. Another person's record stated they had been given £100 for three consecutive months. They had signed the record but there was no information to show they understood how to keep their day to day money safe; receipts were not available.

We checked people's facilities for keeping their valuables safe and found they were not satisfactory. Some people's doors did not lock so items kept in their room were not protected. Some people had lockable drawers but keys were not available so items could not be locked away. A relative told us, "[Name of person]'s possessions are safe, nowhere can be locked but nothing goes missing". The manager agreed to introduce more robust arrangements for safeguarding people's finances. We concluded the provider's systems and processes around safeguarding people's finances were not established and operated effectively to prevent abuse of people who used the service. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the systems in place for managing medicines and found some aspects were well managed, however, we found examples where the provider was not following safe medicine practice. Staff told us one person received medication covertly. Covert administration is the term used when medicines are administered in a disguised format, without the knowledge or consent of the person receiving them. National Institute for Health and Care Excellence (NICE) guidance states providers should ensure that the process for covert administration of medicines includes assessing capacity, holding a best interest meeting involving care home staff, the health professional prescribing the medicine, pharmacist and family member or advocate, planning how medicines will be administered and regularly reviewing whether covert administration is still needed. NICE guidance for managing medicines in care homes provides recommendations for good practice around management of medicines.

We found the provider was not adhering to NICE guidance because they had not completed an assessment around medicines and had not held a best interest meeting or involved a pharmacist. The person's medication had been reviewed by their GP; some medicines were discontinued and others were changed to soluble or liquid preparations. The person's relative had been consulted about the decision and had signed to say they agreed with the need to give medicines covertly. A nurse practitioner had listed the person's medicine and said 'the following can be crushed and mixed with water to aid administration' but they did not refer to covert administration.

The person's medication administration records (MAR) and care plan did not make reference to the person receiving their medicines covertly. The last update, in November 2017 stated, the person had started to refuse to take their medicine and the 'GP was going to see about giving liquids'. When we returned to conclude the inspection we saw the manager had completed a mental capacity assessment and a best interest decision record. This confirmed they had liaised with relevant health professionals and a relative who all agreed covert administration was in the person's best interest.

Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal of CDs. We saw the service stored controlled medicines in a locked cupboard and maintained a ledger, in line with current legislation. However, a CD had been administered the previous night by a district nurse and was not recorded in the ledger, meaning the count was not accurate. The manager said they would investigate why this had happened.

Some medicines were delivered via a patch applied to the skin. Staff understood the site should be rotated to ensure adequate absorption and protect the person's skin, however, the site of application was not recorded so they could not evidence this took place.

When medicines were no longer required, they were recorded in a dedicated book and stored in a bag in the medicines room until they were collected for return to the dispensing pharmacy. We saw a bottle of a CD had been placed on top of the bag and although it was recorded in the returns book, the storage did not

comply with legal requirements of managing controlled medicines as it should remain locked in the dedicated CD cupboard until collected.

MARs included a photograph of each person to aid staff in identifying the correct person. Known allergies were recorded. Most records had been printed by the dispensing pharmacist and included pictures of each medicine. The MAR for one person had been handwritten but not signed or dated by a member of staff. This was for a medication patch and had been handwritten for several months. The manager thought this was because it was for a controlled medicine or because the medicine was out of synchronisation with regular monthly prescriptions. They agreed to address the lack of detail on the handwritten MAR.

MARs did not specify times for administration and terms such as morning and night were used. Where medicines were time critical the exact time required was recorded. Staff said they ensured they left adequate time in between regular doses of medicines, for example, four hours between administering paracetamol. However, they did not currently record exact times of administration but said they would do this in future.

People's care records included a list of the medication they received and what they were for. One care file did not include these details but referred to the British National Formulary (BNF) however this was not available when we visited. Staff said it had been thrown out as it was out of date and the manager said they had requested a new copy from the pharmacy twice. Patient information leaflets from medication packages were retained in a folder but staff were unsure if this was up to date. We concluded medicines were not managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A system was in place so that medicines were ordered in time to be available when people needed them. We checked the count for two 'as required' or PRN medications and they were accurate. People had PRN protocols so staff knew what the medicine was for, how frequently it could be given and how the person communicated they needed it.

Medicines were stored in a locked room, within a locked trolley, fridge or cupboards. The temperature of the room and fridge were maintained at safe levels and this had been checked and recorded every day. We saw a list of names and signatures of staff who had been trained and assessed as competent to administer medicines. We reviewed two staff files and saw both staff had their competency assessed within the last 12 months.

We observed the administration of medicines to five people. The care worker checked the MAR, prepared the medicines and took them to the person. They offered PRN medicines and asked people if they were ready for eye drops or inhalers before collecting them. The MAR was signed after medications had been given. This ensures that if people refuse or are unable to take medication, it has not been signed for in error.

Systems were in place to assess and manage risk although documentation was not always clear and this could result in risk being inappropriately managed. The provider used screening and risk assessment tools to help identify when people were at risk, and care plans were then developed to ensure staff understood how the identified risks should be managed. Risk management included areas such as pressure care, mobility, falls, and nutrition. We saw examples where risk was well managed, for example, two people were at risk of developing pressure sores and during the inspection we saw staff ensured appropriate equipment was used. However, we also saw one person's risk assessment was incorrectly scored so the level of identified risk was incorrect. We brought this to the attention of the manager who arranged for a new risk assessment to be completed. Risk assessments and care plans around mobility and falls were duplicated

and sometimes provided conflicting information so it was unclear how the risk should be managed. The manager said they were streamlining and improving their risk assessment process.

We looked around the home, which included some bedrooms, bath and shower rooms, and communal living spaces. The home looked well maintained, clean and tidy. There was an odour in one specific area of the home and this was noticeable on both days of the inspection. The manager said they were replacing the flooring which would address the problem.

Throughout the service we saw personal protective equipment (PPE) such as gloves and aprons, sanitiser, liquid soap and paper towels was available, and staff were observed using it appropriately. We saw housekeeping staff working during the inspection, mopping floors, and cleaning bathrooms, toilets and communal areas. One person told us, "They keep it spotless."

Certificates and records confirmed checks had been carried out to make sure the premises and equipment were safe although there was an issue with one shower room. Hot water temperature checks were carried out monthly but these did not include the shower room. We tested the temperature of the shower which was very hot when put on the highest setting. We also noted the water was slow to drain; the shower drain cover had been removed and some debris was floating in the drain hole. The extractor fan in the shower room did not work initially when we tested it and there was no record to show this had been checked or serviced. When we returned to conclude the inspection we found the provider had arranged for the shower to be fitted with a thermostatically controlled valve and the issue with the drain had been resolved on a temporary basis. The manager said the provider was looking at a long term solution which would involve altering the position of the drain. They had added the extractor fan to the contractors list.

In-house maintenance records were completed at regular intervals and covered areas such as fire alarms, window restrictors, and wheelchairs. Bedrooms checks were completed monthly and included lighting, furniture, flooring, bed, decoration and radiator checks.

Staff we spoke with knew what to do in the event of a fire, and said alarms were tested every week and a drill took place simulating a fire breaking out in different areas. Staff said personal emergency evacuation plans (PEEP) were updated every month.

People who used the service, visiting relatives and staff told us they did not have any concerns around the staffing arrangements; they told us there were enough staff to meet people's needs and the same care workers provided support so consistent care was provided. One person said, "They come pretty much straight away if I want something." Another person said, "There are the same staff all the time, not many new faces." During our visit we saw care workers were visible and available to support people who used the service.

We reviewed staff rotas for the four weeks before the inspection and saw staffing levels were consistent and shifts were covered by regular workers. The manager confirmed they had one staff vacancy and were in the process of interviewing for this position. They said they had not used agency staff since November 2017.

Recruitment checks were carried out but these were not always done robustly. We looked at two files for staff who had been recruited in the last six months. We saw Disclosure and Barring Service (DBS) and proof of identity checks had been completed.

Safe recruitment practices must include satisfactory evidence of conduct in previous employment. We saw the provider had only completed this for one candidate. The other candidate only had two 'personal

references' and one of these was from a relative. The manager said they had requested employment references but a previous employer had not responded. There was no record of this in the candidate's file. Risk assessments were not completed when the provider did not have full information to demonstrate staff employed were suitable.

Each candidate had completed an application form which detailed employment history and we saw the provider had explored gaps in employment but had not done this fully with one candidate because dates did not correspond. The manager understood the recruitment process and acknowledged they had not followed this robustly. They agreed to review staff files to make sure all the required information was available and ensure a robust process was followed in future.

The manager told us they were keen to work with other agencies to improve their systems and processes. They felt this was a positive experience and provided opportunity to learn when things went wrong.

Requires Improvement

Is the service effective?

Our findings

We received a positive response when we spoke with staff about the support they received from the manager and colleagues. For example, one member of staff said, "We have a really good team. Everyone knows what they are doing. New starters are taught how to do things and do them properly. They are told about good practice. We get good support."

The manager maintained a training, supervision and appraisal overview which showed the support each member of staff had received. The training matrix identified the mandatory training staff must complete and the how often it should be refreshed. The training sessions included areas such as safeguarding, moving and handling, infection control, health and safety, fire safety, food hygiene, dementia, person centred care and challenging behaviour.

Staff told us the training around supporting people with behaviour that challenges was in the form of reading information in a booklet and then answering a questionnaire. Staff we spoke with described how they supported individuals who sometimes became agitated or upset including using distraction techniques.

We saw from the training matrix staff had completed sessions but these had not always been refreshed within the required timescales. For example, the matrix stated staff should receive fire safety training annually but we saw only eight out of 25 staff had completed this in 2017/2018. Safeguarding should also be completed annually and only ten had completed this in 2017/2018.

We found new members of the care team did not receive an appropriate induction. The manager said new care workers did not complete the Care Certificate which is a set of standards for social care and health workers aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification). The manager said new members of staff completed the provider's induction. We saw the induction covered 37 areas such as orientation of the home, call system, policies, procedures, emergency numbers, role of seniors, dignity and respect of residents, and equipment and training expectations. There was no information about meeting people who used the service and reading care plans. We saw a recent starter had signed to confirm they completed the induction in one day.

One member of staff who had commenced in the last six months did not have an existing qualification in care so should have completed the Care Certificate. Another member of staff stated in their application form they had a qualification but the manager said they had not seen confirmation of this. The training matrix showed both staff had completed four training courses; moving and handling, infection control, fire safety and practical fire extinguisher training. They had not completed other mandatory training such as health and safety, safeguarding and mental capacity training.

The manager said staff should receive four formal supervision sessions and an appraisal every year. The supervision matrix showed most staff had received two supervisions in 2017; one member of staff had received the required four sessions; three had received three sessions. Only two staff had received

supervision since August 2017. The appraisal matrix showed four out of 25 staff were still to receive their annual appraisal.

The manager was confident staff felt well supported but told us they had identified some refresher training was overdue and not all staff had received the agreed number of formal supervision support sessions during 2017. They said they had focused on ensuring staff had received an annual appraisal and were working through training and supervision requirements. We concluded the provider did not ensure staff received training and supervision which ensure they were equipped with the skills and knowledge to support people effectively. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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).

At the last two inspections we have found the provider was not meeting the requirements of the MCA. At the last inspection we reported that the management team had taken some steps to address mental capacity and best interest decision making, however consent to some restrictions, was not always sought from people in line with legislation. At this inspection we found there were still issues around the provider's systems and processes in relation to assessing people's capacity, and progress was limited, although we did not find they were in breach of regulation.

We saw in people's care files mental capacity assessments and best interest decision records had been completed but did not always demonstrate how capacity had been assessed or agreements around best interest had been decided. For example, on two people's 'best interest meeting record form' under the section of 'nature of proposed care/treatment or decision to be made', it stated, 'please refer to all cares and risk assessments in care plan and mental capacity assessment'. There was no record of the decision that was being made.

When we returned to conclude the inspection the manager showed us two examples of mental capacity assessments and best interest decisions they had completed following the first day of the inspection. These were carried out to a much higher standard. For example, one assessment evidenced discussions with the person and confirmed based on the balance of probability the person lacked capacity. A best interest decision was made and included health professionals and a relative.

The manager and staff had completed mental capacity training although it was evident from discussions their knowledge around MCA was limited. One senior member of staff said, "We encourage people to do things but they have rights not to do things. I don't really understand capacity though." Staff understood DoLS were sometimes necessary to ensure people's safety, when they lacked capacity. However, staff were unsure how many people had an authorised DoLS. The manager wrote to us after the inspection and confirmed they had purchased additional mental capacity guidance and was arranging additional training and had held a staff meeting to discuss mental capacity.

Staff discussed how people consented to care and support. One explained that some people with dementia could forget and so delivering personal hygiene could involve them asking the person several times, if they

were happy for different parts of the process to take place. People who used the service confirmed staff did this consistently. One person said, "They always explain what they are doing and ask if it's OK." Another person said, "The place suits me and I do what I want to do." Another person said, "It's easy to do what you want, join in or watch or go out for a walk." During the inspection, we observed staff obtaining verbal consent from people. For example, we saw staff asking people what they wanted to do, what they wanted to eat and drink and if they could support them with personal care.

Some people told us they had signed care documentation to confirm they agreed with the care plans. One person said, "I signed my care plan at the beginning." Another person said, "My daughter signed that for me." A visiting relative said, "I have seen the care plan and agreed to it." We saw care files included consent forms for care and support, and photography but these were not always signed by people, even when they had capacity to make their own decisions.

Before people came to live at the home a pre-admission assessment had taken place. The provider also gathered details of people's histories preferences, dislikes and details of activities they enjoyed and family and social interactions that were important to them. When assessments had shown a risk, we saw a care plan had been developed to minimise the risk, for example when a person was at risk of pressure ulcers. They used standard documentation which covered key areas of care, such as communication, continence, mobility, personal care and independence, mental state and cognition.

People told us they enjoyed the food. One person said, "Lovely meals, plenty and a good choice." Another person said, "The food is lovely, top notch, I enjoy all the meals." A relative said, "The food is quite good, it looks and smells nice, there is a wide variety." People told us they had plenty to eat and drink.

We observed people's dining experience and saw meals were well presented and the portion size was good. The courses arrived from the kitchen individually on a tray with a plate cover and cutlery. People enjoyed their food and many cleared their plates. One person said, "The food's perfect." Earlier in the day we observed a member of the catering team taking individual orders from people in their rooms and communal areas. The dining room was clean, bright, and welcoming. The tables had a small centre decoration and a picture menu. Some people ate in the lounge.

The head cook told us people were offered their main meal at teatime. They said people often had a good breakfast and then didn't want a main meal at lunch and a light meal at teatime. The head cook told us meal arrangements had been changed because 'it was better for people' and this worked well.

Menus followed a four week rota. We saw the main meal options were varied and included dishes such as braising steak with onions, potatoes and mixed vegetables, pork casserole, potatoes and cabbage, and Lancashire hotpot. Alternative meals were not included on the menu. The head cook said options were always provided and included jacket potatoes and omelettes.

We saw where people were at risk of dehydration or malnutrition, care plans were in place to make sure their needs were met. One person had a plan for hydration to ensure they received adequate oral fluids. It was very detailed and followed current best practice guidelines by specifying a specific minimum volume of fluid they should receive each day, calculated using the person's body weight. Another person had a risk of malnutrition and a care plan had been developed to ensure adequate nutrition.

People's health needs were met. People we spoke with told us they had good access to health services and other professionals. A relative said, "They order ambulances for eye-tests and hospital appointments." Records of appointments with or visits by external health professionals were maintained. These included

the chiropodist, GP, dentist and District Nurse.

People were comfortable in their environment and had been involved in deciding the décor and themes displayed around the home. The programme of decoration was in progress. A relative told us, "In the last six months there has been a vast improvement in the decoration and flooring." We saw walls had pictures and photographs that were of interest to people, for example, local areas and holidays. There was a large mural of a sweetshop in one lounge and a seaside in one of the bathrooms. A family tree was being developed. People used two lounges and a dining room to socialise. One lounge was busy at times, and a relative commented this 'can seem crowded'. There was ample seating shared between the lounges. We saw people's bedrooms had personal touches and some people had brought items of furniture when they had moved in. People had access to an enclosed outdoor area. Staff told us this was well used during the summer months.

Good

Is the service caring?

Our findings

People told us they were happy living at Stockingate Residential Home. They said staff were kind and caring. One person said, "I am definitely happy with the service." Another person said, "I chat to the staff everyday about my care and other things." Another person said, "They are not like staff, more like family." Visiting relatives also told us people were well cared for. One relative said, "The staff are friendly and helpful, they deserve medals, they give personal care."

During our visit we saw people were treated with kindness. One person started getting distressed; we observed a care worker holding their hand and gently asked if they needed anything. When staff administered medicines we saw people were greeted warmly by name and given time to take their medicines without being rushed.

Staff were confident people received good care. They discussed the ways in which they encouraged independence and protected people's privacy and dignity. For example, they told us about a person who used a mobility scooter and really enjoyed going out alone. They said the person had occasionally forgotten how to get back and discussed plans in place that balanced their independence, enjoyment and safety. This showed they understood good care principles and respected people. One person who used the service had an advocate appointed; staff were aware of this and understood the role of the advocate.

People who used the service and visiting relatives told us staff were respectful and promoted independence. One person said, "They respect my privacy and dignity, knocking on the doors and closing the curtains." A visiting relative said, "They allow him to try to do things before helping him."

Visiting relatives told us they were made to feel welcome whenever they visited. Staff told us they always greeted people at the door and offered them a drink when they arrived. They said some relatives ate meals at the service and we observed this during the inspection. One member of staff said, "I know everyone who comes by name." When we arrived to carry out the inspection, we were greeted cheerfully at the entrance and offered drinks.

During the inspection we saw examples where people's individual needs and preferences were taken into consideration when care was delivered. One person enjoyed singing, and during the inspection we saw several staff encouraged this. Another person enjoyed sweets and we saw staff checked they were given these. Staff described how they supported one person who was registered blind by touch and placing their hands to indicate the location of drinks or food. They said the person could get agitated and anxious if they could not hear music or voices so always ensured the radio was on or someone was talking to them.

When we looked around the service we saw there was information displayed around the service which helped to keep people informed. Picture menus were used to help people choose their food.

In the entrance there were notices and leaflets around activities, how to make a complaint, infection control and safeguarding. The rating from the last inspection was displayed. Care records were stored securely

which ensured confidentiality was maintained.

Good

Is the service responsive?

Our findings

People's care records had information about their lives before moving to Stockingate Residential Home, their preferences, dislikes and details of activities they enjoyed and family and social interactions that were important to them. When we spoke with staff, they were able to tell us about people's background, friends and family and preferences. Staff told us that knowing people well was an important part of delivering effective care and support.

The manager discussed the assessment and care planning process which included assessing people's needs before they moved into the service. Assessments and care plan documentation prompted assessors and reviewers to consider people's communication needs, preferences and characteristics protected under the Equality Act such as gender, religion, sexual orientation and disability. Some people told us they visited the home before they decided to move in. One person said, "I came in two to three times to find out what it was like." People who used the service and relatives told us they were involved in planning and reviewing care. One relative said, "I am involved in the reviews of the care plan."

Care plans we reviewed were generally detailed and person centred. They included how independence was promoted. For example we saw one person's plan specified exactly what they could do for themselves and when they needed support. Care plans included areas such as communication, continence, mobility and personal care. One person who had been discharged from hospital in December 2016 had been cared for using an end of life plan. They had responded to effective care and support and no longer needed palliative care.

Records showed people were asked about their future care wishes which are known as advance decisions. When we visited a person was receiving end of life care and we saw discussion had taken place with the person's next of kin to plan their care. The GP had reviewed medication and district nurses had assessed the person and attended when necessary to administer pain relief medication. This showed people were supported at end of life to have a comfortable, dignified and pain free death.

We noted some people had multiple care plans for mobility and falls and it was difficult to find out if care was appropriate. For example, one person had a care plan that stated they walked with staff, a second care plan stated they walked with a frame and made reference to preventing falls, and a third care plan referred to a sensor mat to help reduce the risk of falls. People did not have care plans around the support they required in relation to management of personal finances. The manager said they were streamlining risk assessments and care plans, and would prioritise the areas of concern we identified during the inspection.

Some information about people who used the service was written on a white board in the manager's office and included DNACPR (Do not Attempt Cardiopulmonary Resuscitation), Deprivation of Liberty Safeguards, allergies, dietary needs and mobility. This ensured staff had access to essential information that helped them to care for people effectively. We saw this was up to date and matched information in people's care files.

We received a positive response when we talked to people about activities. People were complimentary about the activity co-ordinator. One person who spent most of their time in their room said, "The activities lady comes into my room." Another person told us they enjoyed crafts and bingo, and said, "There is plenty to do." A relative said, "The activities are brilliant, spot on."

The activity co-ordinator kept a daily record of every person's involvement and ensured everyone received opportunity to engage in social and leisure activities. These were then used to inform a monthly evaluation of involvement.

The choice of activities was varied and displayed in the entrance, and included reminiscence and sensory sessions, art, manicure and beetle drive. We saw there were group and person centred one to one activities. The activity worker told us the programme was designed so there was something for everyone including sensory engagement for people with more complex needs. Some external facilitators visited the service and provided keep fit classes, pet therapy and a bible study group. People who used the service also attended community activities which included tea dances and brass bands. People were attending a pantomime in the local community centre a few days after the inspection.

People who used the service and visiting relatives did not raise concerns about the service. They said they knew how to make a complaint and would feel comfortable raising concerns with either staff or the manager. One person told us they had previously made a complaint and had received a positive response. Another person said, "No, I haven't wanted to complain. If I had any problems I would just go to the office."

Staff we spoke with understood the complaints procedure, which was displayed in the service. They said they would try to deal with any issues or complaints themselves, and document and discuss the concerns with the manager. If people were dissatisfied with the response they would then be asked to put their complaint in writing.

We looked at records of complaints and saw two had been received in the last 12 months. Complaints were logged with details of other professionals involved, actions taken and the outcome. Copies of correspondence and details of any relevant meetings were also filed. We saw any issues raised were investigated and where possible resolved to the satisfaction of the person.

We saw thank you cards displayed; these complimented the service on the standard of care provision.

Inadequate

Is the service well-led?

Our findings

At the last four inspections the service has been rated as either inadequate or requires improvement. In January 2015 they were rated as inadequate. In July 2015 they were rated as requires improvement. In July 2016 they were rated as inadequate. In November 2016 they were rated as requires improvement. At this inspection they have been rated as requires improvement.

At the last two inspections we found the provider was not meeting the requirements of the Mental Capacity Act 2005. At this inspection we found there were still issues around the provider's systems and processes in relation to assessing people's capacity, and progress was limited, although they were no longer in breach of the relevant regulation. We found they were in breach of four other regulations which related to management of medicines, safeguarding people's finances, staff support and good governance. The findings of this inspection and the provider's inspection history have demonstrated there are widespread and significant shortfalls in the way the service was led.

The provider had a range of audits and checks in place but these were not always effective. We reviewed five different audits from December 2017, which included care files, kitchen and hand hygiene and saw no issues or actions were identified.

The provider had carried out a 'six monthly home audit' on 13 December 2017; the service had scored 86% and was awarded a 'green' rating. The audit said some staff training was overdue but there was no action plan to show how and when this should be addressed. The audit did not identify staff supervision was not being provided on a regular basis and recruitment checks had not been carried out robustly. We saw they had noted that accident and incident reports were being completed but had identified that there was no formal review of trends and possible actions. The manager showed us a new accident analysis that had been introduced and completed in December 2017.

The hot temperature of the shower was not picked up during the health and safety checks. The provider had audited one person's financial record in September and November 2017 but had not picked up there was a lack of information around expenditure to safeguard the person's money. We concluded the provider did not operate effectively systems and processes. The systems and processes did not enable the registered person to assess, monitor and improve the service or assess, monitor and mitigate risk. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager at the time of the inspection. A manager was in post and told us they had started the process to apply to be registered with the Care Quality Commission. We received positive feedback about the manager. One person said, "I know who the boss lady is, she's OK." A visiting relative said, "She is lovely." Everybody told us the service had a good atmosphere and would recommend it to others. One person said, "It's a nice place, friendly and jolly." A visiting relative said, "It's brilliant, we are content we would recommend it."

Staff told us the manager was very supportive. One member of staff told us the manager had been flexible

which enabled them to work and study. They said, "She listens." Another member of staff said, "She has had a very positive impact on the service. There was a lot for her to deal with and we are not perfect, but we are getting there." They said the culture was open and honest, and everyone could speak out at staff meetings.

People who used the service, visiting relatives and staff had opportunities to share their views, and their ideas and suggestions were acted upon. Regular meetings were held. A relative told us they had attended meetings and said, "They listen to what you say." A member of staff told us it was shared at a team meeting that more bed linen was needed and said this was sorted shortly afterwards. A quarterly newsletter was produced to keep people updated about the service.

We reviewed resident meeting minutes from November 2017 and January 2018. These showed people had provided feedback about activities, cleaning, menus, redecoration and the laundry. Staff meeting minutes from September 2017 showed discussions were held around the role of senior care workers, laundry, driving improvement and the trial introduction of non-uniforms.

The provider had sent out a survey in June 2017. Ten were returned. The manager said the results had not been formally analysed but each questionnaire had been reviewed. We saw people had responded positively about the service which covered areas such as the environment, standard of care, quality of food, and friendliness and skills of the home manager and staff. One person had raised concerns in the survey about hydration, inconsistencies around visitors being given drinks and information sharing around medical appointments. The manager said the feedback was shared with staff but this was done informally so no record was available. They told us the provider had devised a new survey and would be sending these out shortly.

During the inspection the manager responded to the issues raised at the inspection and started making changes to improve the service. They provided evidence after the inspection to confirm they were continuing to follow up actions and make further changes. For example, they contacted an external organisation to arrange additional training and purchased relevant guidance. They held an extra staff meeting where they discussed mental capacity and best interest decisions.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes around safeguarding people's finances were not established and operated effectively to prevent abuse of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effectively systems and processes, and the systems and processes did not always enable the provider to assess, monitor and improve the service or assess, monitor and mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff received training and supervision which ensure they were equipped with the skills and knowledge to support people effectively.