

The Franklyn Group Limited

Stobars Hall

Inspection report

Kirkby Stephen
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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

This unannounced inspection took place on 13 June 2016. We last inspected Stobars Hall in July 2014. At that inspection we found the service was meeting the regulations that we assessed.

Stobars Hall is set in extensive grounds on the outskirts of the town of Kirkby Stephen and is registered to accommodate up to 38 people. Rooms in the home have views over the gardens, surrounding countryside and hills. It is a period property and as a result the communal rooms and bedrooms have many original features. There are three lounges and two dining areas on the ground floor. There is car parking available and the gardens are accessible for wheelchair users. At the time of the inspection there were 21 people living at the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The registered manager had notified the CQC of any incidents and events as required by regulation. However a safeguarding notification had not been managed well and appropriate forms used to notify CQC were not used. We recommended that the registered provider sought training for the management team on the handling of notifications to CQC.

People living in Stobars Hall told us that they felt safe living there and friends and relatives we spoke with told us they were "satisfied" with the care being provided. We saw that the people who lived there were well cared for, relaxed and comfortable in the home and the atmosphere was open and inclusive. Everyone we spoke with praised the staff who supported them.

The environment of the home was welcoming and the communal areas were decorated and arranged to make them homely and relaxing and we found that all areas were clean and free from lingering unpleasant odours.

People were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit the home. People were able to follow their own interests, practice their religious beliefs and see their friends and families as they wanted.

The staff on duty we spoke to knew the people they were supporting very well and their lives and preferences. Staff were aware of the choices people had made about their care and daily lives. People had a choice of meals and drinks, which they told us the food was "good" and "lovely" and that they enjoyed their meals.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

The service worked with local GPs and health care professionals and external agencies such as social services and mental health services to provide appropriate care to meet people's different physical, psychological and emotional needs.

The staff we spoke with were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual. We looked at the risk assessments in place for people and these included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition and for the management of a condition such as diabetes.

We looked at the risk assessments in place in regard to fire and how people would be moved in the event of fire. There was an overall fire risk assessment in place but this was overdue for a thorough review. The registered manager confirmed they would be contacting the Fire officer to take advice. We also passed this matter to the Fire Officer for Cumbria so they could follow this matter up with the registered provider and visit the service.

Systems were in place for the recruitment of staff and for their induction and on going training and development. Staff training was provided and staff said they were well supported.

The organisation had written policy on making adjustments to staffing numbers when needed. This showed the process that was used to assess staffing levels. This was to be done on an individual basis and at a frequency decided by the registered manager or senior care staff in line with needs. We recommended that the registered manager found out about systems that could be used to formalise and record this assessment process. There was a 24 hour on call system for staff to access management support if needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

There were adequate staff on duty to support people.

Staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

Is the service effective?

Good ●

The service was effective.

Staff knew the people who lived there well and worked with other agencies and services to help make sure they got the support they needed to maintain their personal needs and preferences.

People were having their individual needs and preferences assessed to promote their best interests in line with legislation.

People had a choice of nutritious meals, drinks and snacks.

Is the service caring?

Good ●

This service was caring.

People told us that they were well cared for and happy living in the home. We saw that people were treated with respect and kindness and their independence, privacy and dignity were being protected and promoted.

Staff demonstrated good knowledge about the people they were supporting, for example detailed information on their backgrounds, their likes and dislikes and daily routines.

Is the service responsive?

Good ●

The service was responsive.

We saw that people made their own choices about their daily lives in the home. There were organised activities for people if they wanted to take part.

Support was provided to help people to follow their own interests and faiths and to maintain their relationships with friends and relatives.

Information was displayed on how to make a complaint within the home. There was a system in place to receive and handle any complaints raised.

Is the service well-led?

The service was well led.

People who lived in the home were asked for their views on how they wanted their home to be run and their comments were listened to.

Quality audits were used to monitor care planning, medication management and service provision.

Staff told us they felt supported and listened to by the registered and deputy manager.

Good ●

Stobars Hall

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.

We visited the home on 13 June 2016. The inspection was carried out by an Adult Social Care (ASC) Inspector.

We spent time speaking with and observing people and staff in various areas of the home including the dining rooms and lounge areas on both sites. We were able to see some people's bedrooms and bathrooms and the communal bathrooms.

During the inspection we spoke with six people who lived in the home, two relatives, four of the care staff, a member of the domestic staff, the registered manager and a company director. We spoke to people living in the home alone and in groups, in private and in communal areas.

We looked at care plans for five people living in the home, their medication records and care plans relating to the use of their medicines. We observed medicines being handled and discussed medicines handling with staff. We checked the medicines and records for six people and spoke with members of nursing and care staff with responsibility for medicines.

We looked at a sample of the records relating to the maintenance and management of the service and records of checks being done on how quality of the service provision was being monitored. We also looked at the staff rotas for the previous two months and staff training records.

Some people living at the home could not easily give us their views and opinions about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us better understand the experiences of people who could not easily talk with us. It is a useful tool to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the registered manager had made under Deprivation of Liberty Safeguards (DoLS).

The registered manager of the home had not completed a Provider Information Return (PIR). 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 were aware of the reasons this had not been done as the registered manager had not received the document. The PIR provides an opportunity for providers to share information and evidence about their service. This is used by inspectors to help plan inspections. The information providers give us is considered alongside all other sources of evidence, including inspection visits. However, judgements about the overall quality of services and ratings of a service are not based on the PIR but on information gathered across the whole inspection process, which was designed to be able to proceed without a PIR in the event of technical or other difficulties.

The process for requesting PIRs is being refined and we encourage providers to sign up to the provider portal. This will enable more reliable delivery of PIRs to services to complete and reduce the likelihood of failures to receive a PIR.

Is the service safe?

Our findings

The people we spoke with who were living at Stobars Hall spoke positively about their home and the staff supporting them. One person told us "I'm very comfortable here, I'm well cared for" and another told us "I do feel safe here, there always someone about if I want them". Another person told us "I have a bell, I take it with me inside and out, they come pretty quick when I ring it". We observed that people did have their bells within reach whilst in their bedrooms.

We spoke with people's relatives as they visited the home. They told us that they did not have any concerns about how their relatives/friends were looked saying "I can't think of anything we don't like here, the staff are good and very welcoming".

People living at Stobars Hall told us that staff were available to help them when they wanted them. We saw that there were three care assistants during the morning and also a senior carer as stated on the rota. During the afternoon we saw there were two care assistants and a senior on duty and overnight two care assistants. One of these staff remained for a period in the morning to assist morning staff during the busy period when people wanted breakfast or to get up. The registered manager was on duty from Monday to Friday. At the time of the inspection there were 21 people living there.

We asked the registered manager and company director how they assessed staffing levels to make sure they were flexible and sufficient to cover changes in needs or busy times. The registered manager was able to provide us with the organisation's written policy on making adjustments to staffing numbers. This showed the process that was used to assess staffing. This was to be done on an individual basis and at a frequency decided by the registered manager or senior care staff in line with needs. There was an on call system available to staff 24 hours a day to access support from the management team. Staff we spoke with confirmed that they passed on information about any changes and additional needs at staff handover.

The staff we spoke with told us that they passed this information onto the registered manager or deputy and if they needed additional staff for a particular reason. We were told that staff would stay behind and work longer if a situation occurred that warranted it. Staff said they could be called in if needed and that they all worked together to make sure everyone got the care they needed. Staff we spoke with told us they felt they had time to spend with people and we saw that staff spent time chatting with people in the communal areas and assisting them with activities. This was an informal system that relied upon verbal communication between staff and their passing on information promptly and clearly to the right people. At the time of the inspection there was not a formal tool being used to help assess how many staff were needed to meet any changes in people's personal care needs. However the registered manager and company director confirmed that this tool had been developed and was due to be implemented and evaluated. These kinds of formal tools assist in formally assessing how many staff might be needed to support people as their needs increased or changed.

We recommended that the registered manager found out about systems that could be used to formalise and record this assessment process. This was so that they could show clear reporting, an agreed line of

authority and responsibility and how the situation would be monitored. This would help reduce the risk of requests for additional staffing not being followed up.

We saw safe recruitment procedures were in place to help ensure staff were suitable for their roles. This included all the required employment background checks and references from previous employers.

All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. They were also aware of the registered provider's procedures for reporting bad practice or 'whistle blowing'. We saw there was information throughout the home for staff, people living there and visitors to refer to on this topic.

We looked at care plans for five people and saw that needs and risk assessments had been carried out with people. The risk assessments identified actual and potential risks and the control measures and management plans to help minimise them. People's care plans included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition and for the management of a condition such as diabetes.

We looked at the risk assessments in place in regard to fire and how people would be moved in the event of fire. There was an overall fire risk assessment for the service in place but this was overdue for a thorough review and therefore may not be an up to date reflection of current risks. The registered manager confirmed they would be contacting and taking advice from the Cumbria Fire Service to make sure risk assessments reflected best practice. We also passed this matter to the Fire Officer for Cumbria so they could contact the service to follow this matter up with the registered provider and advise and make sure the risk assessments were fit for purpose.

We looked at the way medicines were being managed and handled in the home. We found that medicines were being safely administered and records were kept of the quantity of medicines kept in the home. We counted a sample of eight medicines and compared them against the records and found all the medicines tallied. Training records indicated that staff who carried out medicines administration had received training in line with the registered provider's medication policy. We saw that there were arrangements in place in relation to the recording of medicines and that records had been signed correctly on administration. A person living there told us "I get my tablets on time, the seniors do them".

We looked at the handling of medicines liable to misuse, called controlled drugs. These were being stored, administered and recorded correctly. Medicines storage was neat and tidy which made it easy to find people's medicines. Refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges to help prevent any deterioration of the medicines.

Is the service effective?

Our findings

The staff we spoke with were able to tell us about the needs, interests and personal preferences of the people they were supporting. People told us the staff who supported them knew how they liked to be supported and always checked with them how they wanted to be helped. One person living at Stobars hall told us "They [staff] always ask what I want doing and ask me what I want to wear and show me". Another person said "No one has ever told me I have to do anything I don't want to". One person said to us "My choices are always respected, staff ask me if I agree and is it alright to something".

People living at Stobars Hall told us that they always had a choice of food at each meal and one said "The meals are excellent, I should think restaurant quality" and also "The chef is very good, he comes round most days to ask about the meals and he does me a lovely Thai curry".

We saw that people's care plans had a nutritional assessment in place and that people had their weight monitored for changes so action could be taken if needed. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT) and the information received was in the care plan. There was also information on people's dietary needs such as diabetic diets and soft meals. We saw that lunch was a relaxed occasion and staff spoke with and encouraged people as they served or helped them with their meals. We saw that care staff assisted people in an unhurried way and also prompted and encouraged people, where appropriate, with their meals and drinks.

We could see in people's care plans that there was effective working with health care professionals and support agencies involved in people's care such as local GPs, community mental health teams and social services. The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their physical and mental health needs.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). 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.

We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. Some people were not able to make some important decisions about their care or lives due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision. Records were kept of discussions between people, their GPs and families around care decisions. Staff we spoke with understood the principles of the act and the importance of making sure people who did not have the mental capacity to make a particular

decision for themselves had their rights protected.

We looked at the plans in place for some people who had 'do not attempt cardio pulmonary resuscitation' (DNACPR) documents in place. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. The registered manager confirmed that they would review the forms with the GPs to make sure that good practice was followed.

There was a programme of staff training. Training records we saw indicated that staff were receiving adequate training relevant to their roles and mandatory training such as safe moving and handling first aid and health and safety. New staff told us about their induction training and support and how they worked with senior staff until they had been assessed as competent. This helped to make sure they were prepared for their roles and competent to support people living.

Care staff also confirmed that they received regular supervision from the supervisors and records supported this and that staff had received an annual appraisal. We could see that staff training was being monitored and planned for by the across the year. The registered provider had introduced the 'Care Certificate' into their training programme. The 'Care Certificate' is an identified set of standards that health and social care workers need to adhere to in daily working life.

Is the service caring?

Our findings

All the people we spoke with who lived at Stobars Hall had praise for the care being provided by the staff. We were told by one person that "They [staff] are kind and respectful" and a relative said "We are very satisfied with everything, we can visit as long as we want and the staff bring me a drink and have asked if I want to stay for tea. I often stay quite late and no one minds". One person told us "I get on well with all the staff, I can rely on them" and another commented "They [staff] are always polite to me and always knock and ask if they can come in". One person told us "I think it's one of the better homes, I am quite satisfied with how I am cared for". A relative we spoke with told us "They seem a very stable and caring team, if I can't take [relative] somewhere to an appointment a carer always goes and makes sure [relative] is looked after properly."

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported and engaged by staff and how they were spending their time. We saw that staff took the time to speak with people and took up opportunities to talk with them and offer reassurance if needed.

During lunch we found there was good interaction between staff and people living there and a lot of good humour and conversation. We saw that the staff took the time to chat with people and took up opportunities to interact and include everyone. We saw that people who could not easily speak with us were comfortable and relaxed with the staff that were helping them.

People confirmed to us that their privacy and dignity were respected and said they were always asked how they wanted to be looked after. People told us that they could have visitors when it suited them. All bedrooms at the home were being used for single occupancy. This meant that people were able to spend time in private if they wished to.

We saw that when care staff assisted people with their mobility they made sure that people's clothing was arranged to promote their dignity. This helped to maintain people's dignity and independence. They called people by their preferred names as stated in their care plans.

We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. Bedrooms we saw had been made more personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

The registered manager and all the care staff we spoke with demonstrated an understanding of how important it was to support people and families properly at the end of life. They told us that they were supported by the district nursing service and the person's GP to provide the right care and treatments at the end of a person's life. We saw that people had advanced care plans in place stating their preferences should their health deteriorate or at the end of life. This included where they wanted to be cared for.

Is the service responsive?

Our findings

Information on people's preferred social, recreational and religious preferences were recorded in individual care plans. People living at Stobars Hall told us about the different activities they could take part in if they wanted to. Some people preferred to stay in their own rooms more. One person told us "It's a nice room I like it. I have my flowers to take care of and there is a lovely view. I am very happy here". We spoke with one person about how they used their iPad to Skype their friends and relatives and keep in touch with them.

We spent time with a group of people doing craft projects in the morning and in the afternoon people were engaged in making chocolates. The activities were being led by the homes activities coordinator but we saw that all staff supported people to take part in chosen activities either singly or in groups.

There was a well advertised activities schedule and people told us that they were given a programme of the activities planned for the week so they knew what was going on. People told us about some of the things they did such as musical events and musical therapy, baking sessions, painting, board games and quizzes. There were some activities to help with movement such as armchair exercise and indoor ball games. Several people told us they enjoyed the visits from the PAT (Pets as Therapy) dogs.

The service had a complaints procedure that was on display in the home for people living there and visitors to refer to. There was a system in place for logging any complaints received and what had been done in response. We could see that lessons had been learned from some complaints received and as a result some procedures had been changed. Staff said they felt able to raise any concerns with the registered manager and that they felt able to suggest ideas for improvement

We found that a range of information was available for people in the home to inform and support their choices. This included information about the providers, the activities and outings offered, and information about support agencies such as advocacy services that people could use. People living there told us they were able to follow their own faiths and beliefs. They told us that they could attend religious services if they wanted to and that they could see their own priests and ministers as they wanted to.

Assessments of individual need and risks had been undertaken to identify people's care and support needs. Care plans were developed detailing how these should be met. We saw that care plans were reviewed and updated to show where people's needs had changed so that staff knew what kind of support people required. For example changes in weight that needed to be followed up.

We saw in people's care plans that their health and support needs and preferences were clear and personal information was included. This included the preferred gender of their carers. Where they were able people had signed and agreed their plans and had been involved in reviews with their social worker. Where they could not sign then their representatives with appropriate legal authority had done so.

We saw that everyone living at Stobars Hall had a 'hospital passport', this was information about the person, their health and care needs, medication and what they wanted in order to support them. This was to help

make sure that should a person need to transfer to another care setting quickly all their relevant information would be available.

The personal and background information or 'life stories' that staff had developed with people and their families were aimed at getting a full picture of a person and their lives before they lived at Stobars Hall. Some people we spoke with preferred not to take part in this and their wishes had been respected.

Staff we spoke with had a good understanding of people's backgrounds and lives and this helped them to give support and be more aware of things that might cause people anxiety.

Is the service well-led?

Our findings

People who lived in the home said they knew the registered manager of the service who "popped in occasionally" and saw the deputy manager every day to talk with. One person told us "I do feel the home is run well for us, I see [deputy] a lot, they always have a word, they're easy to talk to". Another said "The deputy is brilliant, if you need anything doing see her". As the deputy acts as head of care within the home a large part of the role is to supervise care staff and the care being provided to people living at the home. As a result of this the deputy is highly visible and accessible to people throughout the day. The deputy is able to discuss and update the registered manager on a daily basis about the care and needs of the people living at Stobars Hall.

People told us that they had the opportunity to attend 'resident' meetings and discuss what was done in their home, such as menus and activities. One person told us "I go to them but there is a lot who really can't contribute to the discussion any more". There were staff meetings being held on a regular basis to discuss work and practices and any changes. Staff told us that as they were a small home they tended to meet up informally as well and discussed current issues on a daily basis, keeping each other updated. We saw that staff did a verbal handover on each shift.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All the staff we spoke with told us that they were well supported in the home. They said they had regular staff meetings and individual supervision to discuss practices, share ideas and any areas for development.

We saw that there was a monthly quality assurance audit carried out by the registered manager. Audits had been done on care plans and medication records on a monthly basis and there was also a weekly stock check of medicines. This was to help make sure that the information on file was up to date and that the correct procedures had been followed by staff. Maintenance checks were being done regularly by staff and records had been kept and we could see that any repairs or faults had been highlighted and acted upon.

The registered provider carried out their own annual internal quality audits and health and safety audits against their own policies and procedures. There were also regular visits from a director of the organisation who carried out their own checks and monitored the internal audits. Incidents were reviewed by the registered manager to identify any patterns that needed to be addressed. There was regular monitoring for individual risks to check if there was a theme or pattern emerging.

The registered manager had notified the CQC of any incidents and events as required by regulation. However on one occasion the registered manager had reported an injury to CQC but they did not notify CQC when another party had referred that incident under safeguarding procedures. They should have done so as a separate notification to the injury. The registered manager has taken advice on this process to prevent the error reoccurring.

We recommended that the registered provider sought training for the registered manager and deputy on the

correct handling of notifications to CQC.