Stoke House Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 6 March 2017 and was unannounced. Stoke House Care Home provides accommodation over two floors for up to 46 older people who require residential and nursing care and treatment, some of whom are living with dementia. On the day of our inspection 29 people were using the service.

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

People were supported by staff who understood the risks they could face and knew how to keep them safe. Risks to people's health and safety were identified and assessed and action taken to reduce risks were known by staff and recorded in people's care plans. People received their medicines as prescribed and these were managed safely.

People were supported by staff who received appropriate training and supervision and had an understanding of people's care needs. People were supported to make choices and decisions for themselves. When people were assessed as lacking mental capacity most people had capacity assessments and best interest decisions in place.

People required more support to protect them from the risks of inappropriate nutrition and hydration and to help them maintain their healthcare needs.

People were cared for and supported by staff who respected them as individuals, staff had friendly relationships with people and respected their privacy and dignity. People were involved in planning and reviewing their own care and some people were supported by relatives in doing so.

People received individualised care and were provided with meaningful interaction and activities. People felt confident to make a complaint and were confident these would be responded to.

We saw that staff worked well as a team and were supported by management to drive improvements in the service. Quality monitoring systems were in place which were effective in identifying issues.

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.

People felt safe using the service and staff looked for any potential risk of abuse and knew what to do if they had any concerns.

Risks to people's health and safety were assessed and staff were informed about how to provide safe care and support.

People were supported by a sufficient number of staff who had been recruited safely.

People received the support they required to ensure they took their medicines which were stored safely and securely.

Is the service effective?

Requires Improvement

The service was not entirely effective.

People required more support to protect them from the risks of inappropriate nutrition and hydration and to maintain their healthcare needs effectively.

People were supported by staff who received appropriate training and supervision and had an understanding of people's care needs.

Peoples were supported to make choices and decisions for themselves. When people were assessed as lacking mental capacity most people had capacity assessments and best interest decisions in place.

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff who respected them as individuals.

People and their relatives were involved in planning and reviewing their own care.

We observed that staff had friendly relationships with people and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received individualised care and were provided with meaningful interaction and activities.

People felt confident raising a complaint and were confident any complaint they made would be responded to.

Is the service well-led?

Good

The service was well led.

People and their relatives had opportunities to provide feedback regarding the quality of care they received. Staff views were also encouraged and listened to.

We saw that staff worked well as a team and were supported by management to drive improvements in the service.

Quality monitoring systems were in place which were effective in identifying and acting on issues.

Stoke House 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 6 March 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider 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 also checked the information that we held about the service such as previous inspection reports, information we had received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with ten people who used the service, six relatives, two members of care staff, a nurse, the assistant activities co-ordinator, the deputy manager and the registered manager. We observed care and support in communal areas. We looked at the care records of five people who used the service, staff training and recruitment records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and provider's representative.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us that they felt safe at the home or that the home was a safe environment for their relation. One person told us they felt safe because staff knew their whereabouts and another person commented that they felt safe because staff were always around. All of the relatives we spoke with were complimentary of the supervision and support their relations received and the reassurance this provided them. One person's relative told us, "[Relation] is safe yes, very safe. There's someone (staff) about all the time." Another person's relative told us, "If I've got any worries I can ring [deputy manager] and they are marvellous, they sort things out. I can go home and sleep at night."

People could be assured that staff knew how to respond to any allegations of abuse. Staff told us they had received training on safeguarding. The staff we spoke with were able to describe the signs and symptoms of different types of abuse and what action they would take if they suspected abuse had occurred. They were confident that any concerns raised with the deputy manager or registered manager would be taken seriously and reported to the local authority. We reviewed our records and found that the provider had shared information with the local authority and us, as appropriate, when they had concerns for someone's safety within the service.

Risks to people's health and safety were identified and assessed in areas such as falls, developing pressure ulcers and nutritional risk. Care plans were in place which provided guidance to staff about how risks could be reduced and people's safety maintained. The staff we spoke with were knowledgeable about the risks to people's safety and the measures in place to keep them safe. For example, one person had fallen and injured themselves and their mobility care plan had been reviewed and updated to reduce the risk of this happening again. A sensor mat had now been placed by the person's bed to alert staff if they tried to get out of bed. Another person was at high risk of malnutrition. Their care plan reflected the level of risk and records showed that the person was weighed regularly, their food and fluid intake monitored and a referral had been made to a healthcare professional for support. These records showed that the person had recently begun to put on some weight thereby reducing their risk of malnutrition.

We observed that equipment was available and being used to assist people to move around the service, request assistance or reduce the risk of falls. People told us that staff used equipment safely. People had risk assessments in place to determine whether equipment was safe for them to use, for example in relation to bed rails or call buzzers. We found that pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and we found these were functioning correctly which ensured they were effective in reducing risks to people.

People had care plans to describe the support they needed to ensure their safety and wellbeing in the event of an emergency situation which would require evacuation. Equipment and safety checks were in place to reduce the risk of harm to people in the event of a fire. We also found that regular checks were carried out to reduce the risk of legionella, scalding and faulty equipment.

People who lived at the service and their relatives expressed mixed opinions on whether there were

sufficient staff on duty to respond to people's needs in a timely way. The majority of people and relatives we spoke with felt there were sufficient staff numbers however one person commented that staff were always busy and a relative told that on occasions it appeared there were not enough staff. We spoke to people who spent time in their bedrooms who confirmed that they were able to request staff support by using a call bell. People told us that sometimes staff came straight away and other times they had to wait for staff to respond.

We observed that people's requests for support were responded to. The staff we spoke with told us that they felt there were generally enough staff to meet people's needs.The provider told us in their PIR that they used a dependency took to assess the needs of people living at the service and the staffing numbers appropriate to meet those needs. We examined staff rotas and saw planned staffing levels were achieved. Staff absences or vacancies were covered by permanent staff or the use of agency staff. Staff confirmed this to be the case. One member of staff told us, "Staffing is a lot better. There is always agency booked (to cover staff absences)," they also confirmed that 1:1 staffing was provided when required.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicant's suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. Recruitment files showed the necessary recruitment checks had been carried out.

People who used the service told us they received support to take their medicines at the time they required them, which was confirmed by relatives we spoke with. One person told us, "The nurse gives me [medicines], I'm on loads. I don't mind because I get it every morning and every time I should have it and on time." Another person's relative told us, "Staff deal with [relation]'s medication now and [relation] gets everything in time. It's all monitored."

People received support to take their medicines from staff who had been trained and assessed as competent to do so. We observed the administration of medicines and saw staff followed safe procedures. However, the morning medicine administration round was not completed until after 11.30am which meant some people received their medicines very late and the timing of their next administration had to be adjusted to ensure there was suficient time between doses for this to be adminsistered safely. We talked with the registered manager about this and they told us they were considering training senior care workers to administer medicines so that two staff could administer the medicines to ensure they were administered in a timely manner.

We found that not all of the medicines administration records (MARs) had a photograph of the person to aid identification. This may increase the risk of incorrect identification of the person, particularly if agency staff undertake medicines administration. A medicines audit had been completed and we saw this issue had been identified and included in a quality action plan for the service with a timescale for completion. We found that other information to aid the safe administration of medicines, such as a record of any allergies, was provided to staff. When medicines were prescribed to be given only as necessary, protocols were in place to provide the additional information required to ensure they were given consistently and safely. One person had been refusing their medicines and permission had been sought from the GP and the pharmacist to administer these covertly, and a covert medicines plan was in place.

Processes were in place for the regular ordering and supply of medicines and these were available when needed. Medicines were stored safely and securely.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the food was good and confirmed that they had a choice of food to eat. One person told us, "Plenty of food. There's always ample variety and always fruit and yogurt. We're getting really good fish which I like." A relative told us, "I asked if [relation] could have a banana every day and they are doing. They wants cheese and tomatoes for breakfast and that's what they get." However, some of the relatives we spoke with expressed concern that their relations was not provided with enough encouragement to eat and drink enough.

We saw that staff provided support and encouragement to people during mealtimes but this was time limited. We saw that some people did not eat much food and on occasion people's meals were taken away without further support or encouragement being offered. We observed during one mealtime a person had said they did not want some soup. This was left in their room but no attempts were made to encourage the person to at this or offer them an alternative. Staff told us that at times it was difficult to monitor how much people had eaten or drank as they did not have time to effectively support everyone, and on occasion meals were taken away before they could record how much the person had eaten. The registered manager told us that following our visit they have reviewed people who require assistance and prompting to eat and had rearranged staff allocations to ensure people received the support they required.

We saw that records were kept to show how much people had eaten or drank but these did not always evidence that people had been offered snacks and fluids on a regular basis. Some of the people whose care plans we looked at stated that the person should be offered something to eat on a frequent basis, and food charts did not always evidence this had happened. The registered manager told us of extra checks they had introduced following our visit to ensure people were receiving support to eat and drink when required.

Our observations identified that people were offered a choice of food and drink. We spoke to the cook who told us they were provided with relevant and up to date information about people's dietary requirements. We saw that people's weight was monitored in line with their care plan and that support had been sought from external healthcare professionals when there had been changes in a person's weight.

Records did not evidence that people were always supported to maintain their healthcare effectively. We found that information in care plans about how people should be supported to maintain their skin integrity was not always clear, for example in relation to the type of equipment required or how often the person should be supported to change their position. Where instructions were provided in relation to how often a person should be supported to reposition we could not be assured this support was provided as frequently as required. For example one person who required support to frequently change their position had no position changes recorded for 19 hours. The person was at high risk of developing a pressure ulcer and should have been supported to reposition every two to three hours. The registered manager told us of extra checks they had introduced following our visit to ensure people were receiving the support they required.

People were supported to see healthcare professionals if needed. One person told us, "We have nurses on all the time. If you want the doctor they get him. They had a dentist come here but I don't think he does now

but they'd always provide a carer to go to one with you." The person also told us that the staff had made arrangements for them to attend a hospital appointment. A relative told us that the staff supported their relation to see a doctor quickly if it was required.

Staff told us that they felt that the support of doctors and external healthcare professionals was sought without delay when required. A member of staff confirmed that they had sought advice from a person's GP on the day of our visit, in response a variation in their healthcare condition. We saw from care records that input was sought from a range of external healthcare professionals such dementia specialists, dieticians, speech and language therapists and opticians when required.

People told us they felt staff were qualified and trained to support them well. One person told us, "They (Staff) use the hoist in a kind, gentle way, explain what they are going to do." A person's relative confirmed this view, and said, "Very much so, they know what they are doing. They'll tell [Relation] what they are going to do."

Staff told us that they received the training they required to undertake their roles effectively. Training was provided via a mixture of on line and practical sessions. Staff were complementary of the practical training they had received in moving and handling and dementia awareness. We observed staff using the skills they had developed; for example, we saw staff safely assisting people to transfer using a hoist and appropriately supporting people with dementia. We accessed training records and saw that staff received training relevant to their roles. A number of staff were due training which the provider had identified was required annually. We saw that a training and development plan was in place which showed when staff were required to have training completed by.

Staff told us that they received supervision and support from senior members of staff and an appraisal of their training and development needs. The provider told us in their PIR that, 'Staff members are asked about their skills and knowledge and if they can identify any areas where they feel they are lacking and need additional support.' The staff we spoke with confirmed they felt able to approach the management team if they required further training.

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 told us that staff supported them to make choices and respected their choices. One person told us, "I prefer a bed bath rather than a shower. They (staff) did give me a choice of a man or a woman carer." Another person's relative told us, "[Deputy manager] asked me about the times (relation prefers to get up and go to bed) and I told them but [relation] changed it anyway and they accept that. [Relation] goes to bed when [relation] wants."

People's care plans considered whether people were able to make their own decisions. Where people lacked the capacity to make their own decision, people had an assessment of their capacity and corresponding best interest decision clearly recorded. We saw that some people had appointed representatives to make decisions on their behalf and this information was recorded. Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form in place and we found these to be completed appropriately.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us, and records confirmed that applications for DoLS had been made for people who were at risk of being deprived of their liberty. Where these had been authorised the registered manager was aware of any conditions attached to the authorisation and could evidence the action taken to meet the conditions. The staff we spoke with were knowledgeable about the principles of the MCA, although they were not sure whether anyone at the service was deprived of their liberty.

People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were care plans in place informing staff of what may trigger the behaviour and detailing how staff should respond. We found that staff we spoke with had a good knowledge of these plans.

Good

Is the service caring?

Our findings

People who used the service described staff as kind, patient and caring. One person's relative commented, "Everybody that works here is lovely, all are very, very caring; they care about the residents. They are always hugging them. It's nice to see. It's always appropriate; it's if they are distressed or unhappy about something. It's the right level of attention and affection." Another relative confirmed this and told us, "Caring; yes. Respect; yes."

We saw that staff had friendly relationships with people and showed a genuine interest in their wellbeing. Staff took time to sit and speak with people, ask how they were and speak about topics of interest to them. There was a lot of friendly banter between staff and people who lived at the service and appropriate physical contact to provide reassurance. For example, we saw the cook talking to a person who appeared distressed. We observed that they maintained eye contact with the person, holding their hand and verbally reassuring them in a kind and respectful manner. We saw many examples of positive and genuine social interactions throughout the day involving different members of staff, including care workers, the registered manager and domestic staff. The staff we spoke with knew people well and were able to describe their individual needs and preferences.

People's care plans contained a good level of information about people's communication needs. We observed that staff used their knowledge of people's communication needs to offer people choices and provide information in a way they would understand. One of the staff we spoke with described supporting a person to open their birthday cards and feel the different textures to involve them as much as possible due to the person's poor eyesight. Another staff member described how they supported a person with hearing difficulties to partake in a quiz by using a microphone.

People's care records contained some information about their life history and interests. We observed that staff used their knowledge of people's interests and their families to instigate conversations. Staff told us that they got to know people through reading their care plans and spending time with them and spoke about people knowledgeably and warmly. The staff we spoke with were aware if people had particular cultural or religious needs and described how this altered the care they provided, for example in relation to the food offered to people.

People told us they were offered the opportunity to be involved in planning their care and relatives confirmed they were also involved in the care planning process and subsequent reviews, if appropriate. We saw evidence of this in people's care records and one person's relative confirmed this to be the case, stating, "We went through all [relation]'s needs, likes and dislikes, everything."

The registered manager was knowledgeable about advocacy provision and told us that an advocate had supported meetings held at the service and had provided individual advocacy for one person when this had been identified as a need. Advocates are trained professionals who support, enable and empower people to speak up.

People were supported by staff who respected their privacy and dignity. One person's relative described how staff supported their relation with personal care and how important this was in maintaining their dignity. A person living at the service confirmed that staff respected their choices and privacy, commenting "I let them (staff) know when I want to be on my own and they respect that."

We observed staff provided support in a way which preserved people's dignity. Staff spoke about people in a respectful way, provided support in a sensitive manner and knocked on bedroom doors before entering. The staff we spoke with were able to describe different ways that they ensured people's privacy and dignity when providing care, for example by closing doors and curtains when providing personal care and supporting people to open and read their own mail when possible.

Good

Is the service responsive?

Our findings

People and their relatives generally felt that that staff responded to their needs in an individualised way. One person's relative told us that their relation could display agitation and that, "They (staff) handle [relation] very well. They let [relation] walk around, give him space." Another relative told us that sometimes their relation was up all night and that staff would stay with them. People expressed mixed views on how promptly their requests for support when using their call buzzers were responded to although most people told us they did not have to wait long.

The provider told us in their PIR that before a person was admitted to the service, 'a thorough pre-admission assessment is carried out and all potential care needs are identified'. The records we accessed confirmed that these assessments were carried out and that care plans had been developed to provide staff with information on people's care and support needs. We found that most of these contained personalised and detailed information which had been updated at regular intervals and when people's needs had changed. However, we found one person's care plan had not been fully updated following a recent admission to hospital and some important information was missing. Although staff were knowledgeable about recent changes and told us they had received training and support, there was a risk that agency or new staff may not have the information they required to support the person in line with their current needs. The registered manager confirmed that the person's care plan had been updated following our visit thereby reducing this risk.

People's care plans did contain information about people's preferences such as when people wished to get up and go to bed and gave consideration to people's level of independence. Staff were aware of the need to give people choices about the care and support they required. Care records contained information about how people should be supported to maintain the independence where possible and staff gave us examples of how they encouraged people to do as much for themselves as they were able.

People told us that there were a range of activities provided in the home, but that if they chose not to join in this was respected. One person said, "I sit and read. They (staff) do organise games and things but I don't want to do that. I'm not bored, I keep myself occupied. They (staff) do take people out shopping and to the garden centre. It's nice, it makes a change." Another person told us, "[Staff member] took me down the road (in a wheelchair) for a walk to see the horses and goats for about an hour and a half. She's taken me out three times. A local ladies choir come in, they are very good. We had a garden party."

The registered manager told us that the home's activities co-ordinator had very recently retired. They told us that they will be recruiting another co-ordinator but in the meantime two care workers had been designated to support people to join in activities. We spoke to one of these staff members during our visit and observed them engaging with people in small groups and individually.

At various times during our visit we saw the staff member supporting a person to have their nails done, playing skittles with a group of people, ensuring a person had a colouring book and crayons and taking two people out to the garden to feed the birds. We saw the staff member encourage a person to put their coat on

before going outside. They did so in a kind and respectful manner and was mindful of risks to person whilst encouraging their independence. The staff member told us they visited people who preferred to stay in their rooms or were unable to leave them due to their health needs and spent time chatting, reading or in one instance taking part in a quiz. A person living at the service confirmed this to be the case and told us, "[Staff member] and a friend came to my room and we had a quiz." The staff member told us that they were supported by the registered manager to provide person centred activities for people.

People told us that they had not raised any complaints about the service but would feel confident in doing so. People and their relatives described what action they would take if they wanted to make a complaint and were confident that both the registered manager and deputy manager would take action to address any concerns. One person's relative told us, "I like everything done right and if it's not I'd be the first to say, I definitely would. I'd go to [registered manager], he'd sort it out." Another relative commented, "I'd go straight to [deputy manager]. If there's anything wrong they are there like a shot. I've no concerns. It would be hard to improve on anything, they are very good."

People could be assured that complaints raised about the service would be responded to appropriately. We saw that a copy of the complaints procedure was on display in the service. Staff were aware of the procedure and told us the action they would take if somebody raised a complaint and felt the registered manager would respond appropriately to any concerns. We reviewed the complaints made about the service over the previous year. We found there was a clear record of the issues, action taken and a record of the feedback to the complaint which had been provided in a timely manner.

Good

Is the service well-led?

Our findings

All of the people we spoke with were positive about the atmosphere in the home. One person's relative told us, "It's nice, warm, friendly. Everybody speaks to you, everybody knows everybody by name." Another person's relative commented, "It's great here, peaceful, clean and the people are nice." People and their relatives were also complimentary of the leadership of the service. One person's relative said that the registered manager was, "very approachable, very lovely. He cares, he's down to earth, and easy to talk to," whilst another told us, "[Deputy manager] is always around. They are very approachable." People and their relatives told us that they felt comfortable approaching and speaking with any of the staff and found them knowledgeable about their relations.

People benefitted from clear and visible leadership within the service. We saw that the registered manager spent periods of time at the service speaking with people and staff. The staff we spoke with were positive about the registered manager and told us they felt confident raising issues with them. One member of staff described the registered manager as, "Calm and interested in everybody as people. If I have things to do, he doesn't mind putting an apron on and helping out. [Registered manager] is an open person; he listens to what you have to say."

Staff told us that there were regular staff meetings and that they felt that communication had been an issue but felt that this was starting to improve. For example, staff told us that they had not always received feedback on their performance or when issues were raised, but this had improved and they did feel able to speak freely during individual supervisions. During our visit we saw that the atmosphere of the service was calm and relaxed and staff worked well as a team. A member of staff told us, "I like the atmosphere here. You can see the difference (in the atmosphere of the service.)" Another member of staff told us, "There's a good team spirit here. I don't see any clashes and the staff do communicate well."

People confirmed that they felt able to make suggestions and contribute to the development of the service. One person told us, "We do have residents' meetings. I do go and make suggestions and they do listen." The person gave us an example of a request they had made during a residents meeting which had been acted upon. People's relatives also felt involved in the running of the service. One person's relative commented, "They have relatives meetings every month. If I had a problem I'd go see [registered manager] or [deputy manager] anyway." We were provided with the results of a relatives' survey which had recently been carried out. An initial analysis had been carried out by the registered manager who told us they would be producing an action plan to demonstrate the action they were taking in response to areas which could be improved.

The provider complied with the condition of their registration to have a registered manager in post to manage the service. We found the registered manager was clear about their responsibilities, including when they should notify us of certain events that may occur within the service. We checked our records and found that we had received the relevant notifications when required.

Systems were in place to monitor the quality and safety of the service. The provider told us in their PIR that an internal auditing process is co-ordinated by the registered manager which included monthly audits of

different areas of service provision. Any areas of non-compliance were then transferred onto an action plan. We found this to be the case during our inspection. We found that regular audits had identified areas of non-compliance such as photos missing from people's medication records and daily recording not covering all shifts. Although these issues had not been resolved by the time of our visit, they had been identified and timescales were in place to attain compliance. We spoke to the registered manager about including an audit of people's care plans and daily care recording to ensure they contained the required information and were being completed and the registered manager confirmed these checks would be carried out in future.

The registered manager also maintained oversight of incidents and accidents which occurred in the service. Incident and accidents were recorded and reviewed by the registered manager who checked that all necessary actions to keep people safe had been actioned. An analysis was completed on a monthly basis to identity any themes and actions taken to prevent reoccurrence were recorded.

The registered manager told us they received the support and resources required to manage the service. We saw records which confirmed that the registered manager was effectively supported and monitored in their role by the provider's representative. Staff also confirmed that they felt supported by the provider and found them to be visible and approachable.