Mr & Mrs J Fieldhouse

Stella House Residential Care 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 23 and 26 August 2016 and was unannounced. At the last inspection on 30 March 2015, we asked the provider to take action to make improvements around record keeping, activities and at this inspection we checked to see the actions had been completed.

Stella House is registered to provide accommodation and personal care for up to 40 people. There were 31 people living there permanently at the time of our inspection and one person staying on a temporary basis. There was a registered manager in post. However, the registered manager was not at the service at the time of our inspection and was due to leave the position. Temporary management arrangements were in place to ensure the home had management support whilst the registered manager was not present. 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.

Staff had been trained and demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Standardised risk assessments had been undertaken for those people at risk of malnutrition and pressure sores. The home completed risk assessments when other risks such as choking, medication, fire and falls had been identified. However, one person who was at the home for a temporary respite stay had not had their risks adequately assessed and recorded in line with good practice guidance. Two people had managed to leave the premises without staff awareness which posed a risk to their health and wellbeing. We also found moving and handling risk assessments and care plans although in place lacked detail to ensure staff had an accurate plan to follow. These issues were raised with the area manager who agreed to act upon this information immediately. However, the failure to assess the health and safety of people using services and have plans in place for managing risk was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication was administered appropriately and all staff who administered medication had received training and had been assessed as competent to administer medicines. We found some minor issues with the management of medicines such as concerns regarding crushed medicines, which the GP had advised was acceptable without a clear indication from a pharmacist that this did not affect the efficacy of the medication or pose a risk to the people using it.

Infection control procedures had improved since the last inspection and staff were aware of the procedures

to follow to ensure the risk of infection was minimised.

Staff undertook a thorough induction when they first started working in the home and we saw this was evidenced in the staff files we reviewed. Staff completed the Care Certificate and the registered manager was the assessor for the certificate.

The home was compliant to the Mental Capacity Act Deprivation of Liberty Safeguards. However, we did not find any recorded decision specific capacity assessments in the care files we reviewed for three people we identified as lacking capacity to consent which was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service was in the process of identifying who had the relevant attorney to be able to consent on behalf of their relation, we found staff had signed consent forms on behalf of people when they did not have the lawful authority to do so. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found all the staff to be caring in their approach to the people who lived there and staff treated people with dignity and respect. Staff knew the people they supported very well and were keen for people to feel they were at home.

Staff recognised the importance of promoting and maximising independence in people's everyday lives and could evidence how this approach had led to improvements in people's abilities.

We found an improvement in daily record keeping at the service. These were completed several times each day giving a chronology of the person's day. Some of the records were very detailed evidencing people had been offered choice in their daily lives and others were more task focussed. We found care plans which had been recently updated were person centred giving detailed information on how to support the person. However, we found no records for one person who was staying on a temporary basis and this person had complex care needs. This omission posed a serious risk to inappropriate care provision and therefore the service was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a significant improvement in the audits undertaken at the service and these audits demonstrated the service was monitoring and improving the quality of the service provided. The service regularly sought feedback from people using the service and their relatives to inform where improvements were required. However, the audit system had not picked up the issue with the lack of recording for people on temporary care.

Regular meetings were held to inform staff about practice issues and to enable the registered provider to have feedback so they could arrive at an informed view about the standard of service provision.

However, two people had be able to leave the building without staff knowing their whereabouts, which demonstrated a failure in the home's systems and processes to ensure the health, safety and welfare of people using the service. This is a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risk assessments had been completed for people who lived permanently at the home, but we found one person on a temporary stay lacked any recorded risk assessment to ensure they were safe.

We found some minor issues with the management of medicines.

Records showed recruitment checks were carried out to ensure suitable staff were recruited to work with people at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had appropriately referred to the local authority where a person was deprived of their liberty under the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards, but we found a lack of decision specific capacity assessments in place for those people lacking capacity.

Staff were receiving regular training, supervision and appraisal to ensure they developed in their role and the service was supported by the local authority workforce development team.

People enjoyed the food and told us they could ask for food and drink whenever they wanted. Where necessary people had their food and fluid intake monitored although not all staff were consistent in the way they recorded this.

Is the service caring?

Good

The service was caring.

People told us staff were caring, compassionate and kind.

Staff knew how to ensure privacy, dignity and confidentiality were protected at all times.

Staff recognised the importance of promoting and maximising independence in people's everyday lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans contained information to enable staff to deliver person centred care such as people's preferences and views. But for those people staying on a temporary basis this recorded information did not contain sufficient detail to enable staff to provide responsive care.

People were provided with activities that were meaningful to them and the new activities coordinator was working on their activity programme to ensure they provided activities which people enjoyed.

People knew who to complain to if they were not happy with the service. The service received very few complaints from people using the service and attempted to resolve individual concerns before they escalated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found the audits at the home had significantly improved. However, they had not identified the issues we found with recording and with medicines.

The service was seeking and acting on the views of people who were using the service and their relations.

Meetings were held with all staff regularly to ensure they encouraged best practice throughout the organisation.

Systems and processed had failed to ensure the safety and welfare of people living at the home and two people had managed to leave the building on more than one occasion posing a threat to their wellbeing.

Stella House Residential 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 23 and 26 August 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors 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 reviewed all the information we held about the service including statutory notifications, and information from partners. We contacted our partners in health, social care and third sector organisations and received information from the local authority in relation to safeguarding and commissioning, Environmental Health, and the CCG.

We spoke with seven people who lived at Stella House and four relatives. We spoke with the registered providers, the area manager, the assistant manager, the cook, three care staff and the activities coordinator.

We observed care interactions, including in the communal and dining areas. We reviewed five care records of people living at Stella House. We also looked at records relating to the maintenance of the home and servicing records.

Requires Improvement

Is the service safe?

Our findings

People living at Stella House told us they felt safe. Some of the comments from people included, "I feel very safe", "Yes I feel safe and I like living here" and "Yes, I feel perfectly safe." All the relatives we spoke with told us their relative was safe.

We had been alerted by a relative that one person had managed to leave the home on several occasions. This person was identified to be at risk of harm when not at the home. We were also told about a second person who had left the home on the first day of their stay. The home had undertaken an investigation of the incident which had also been referred to the local authority safeguarding team and additional safety measures had been put in place. This included only staff having access to the key code to the front door to ensure staff were always aware when people were leaving the home. The registered provider realised this was restrictive but assessed this was the only way they could be assured people did not leave the home when people entered and exited the home. The registered provider was looking into an improved alarm system to ensure people were safe without being overly restricted. However, the failure to assess the health and safety of people using services and have plans in place for managing risk was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we were notified of a further incident where a person living at the home had left the building without staff awareness, when it was not safe to do so and was returned to the home by the police. The lack of adequate systems and processes to mitigate the risk to the health, safety and welfare of these two people demonstrated a breach of Regulation 17 (2) (b) as systems and processes had failed to assess, monitor and mitigate the risk to the health, safety and wellbeing of people who used the service.

The registered provider had developed and trained their staff to safeguarding adults from abuse. The area manager told us they had an on call system and staff who witnessed abuse could call at any time to be guided through the process in addition to the flow chart directing staff. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with described the signs of abuse such as, "Financial, verbal, emotional, and sexual." They described an incident that had happened at the home and what actions had been taken, which demonstrated they knew the process to follow to ensure people were protected from abuse.

We looked at how the service managed risk to ensure people living at Stella House were safe. We found risk assessments in place in the care files of people who lived there on a permanent basis. These included standardised risk assessments such a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition. The service assessed risks around choking, falls, fire, medicines and mobility and put plans in place to reduce the risks. Each person had a Personal Emergency Evacuation Plan (PEEP) in place to enable staff to assist people to evacuate the building if necessary. The home utilised a moving and handling risk assessment and care plan to promote

the safe handling of people at the service. However, we found the information lacked a detailed recording of the method staff were to follow to safely move the person and not all the equipment had been identified in the plan.

We found one person staying on a temporary basis had two falls from a chair whilst at the home. To resolve this issue they had been provided with a chair which had a reclined seat for their own safety to stop them from falling out of the chair rather than to act as a restraint. However, we found this person had no recorded risk assessments or care plans in place apart from their preadmission information. There was no recorded falls risk assessment, recorded mental capacity assessment, recorded care plan or recorded clinical reasoning to determine the suitability of the chair. This was highlighted to the manager who agreed to rectify this immediately. The lack of assessing, monitoring and mitigating the risk to the health, safety and welfare of this person and the lack of an accurate record of their care was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how they would respond in an emergency such as a fall. We were told "Call for the team leader. Do a body check before touching the client. No problems with breathing or levels of consciousness, we would sit them up and see whether they could get up and into a chair. Anyone with a head injury we would call 999." We were shown a post falls checklist which contained a flow chart for staff to follow when a person had a fall depending on whether the person had a slight, minor or major injury. Staff were required to complete a post falls observation, record the accident in the accident book and inform people's families. We reviewed the accident and incident folder to ensure staff were recording incidents as they happened. The accidents had been recorded. However, on the review of accidents there was often a lack of analysis recorded on the form. We identified one person who had fallen several times and reviewed their care files with the registered provider, and found the evidence to support measures had been put in place to reduce further falls. The area manager agreed that this information should have been recorded in one place to evidence they were actively ensuring future incidents were reduced by a thorough analysis.

We asked people who lived at Stella House whether there were enough staff to care for them safely and respond to their call bells. One person told us, "It seems there is an awful lot of staff." By contrast another person said "No there are not enough staff, they are rushing about like mad. They are lovely girls." The relatives we spoke to were very complimentary about the staff and said there were usually enough staff on duty. Specific comments included; "On odd occasions there is no one about but staff have the right skills and seem to know what they are doing". One person said "staff are lovely and cannot fault them although there are sometimes less staff on weekends."

The registered provider employed 26 care staff, six of whom were team leaders. The area manager told us staff had raised concerns four weeks previously to say they were struggling with the increased dependency of people at the service. They told us as a response to this they had recently changed the shift to ensure more staff were available at busy times. For example, they had changed the shift pattern so the day staff started work at 6.40 am and the three night staff finished at 8am which meant there were eight staff working for one hour and 20 minutes to support people to get up and dressed and with breakfast. The area manager told us they had increased the staffing levels at lunchtime by rearranging start times as five people were requiring assistance to eat, so more staff were needed at this time to ensure people's nutritional and hydration needs were met. The area manager told us the service did not employ permanent night staff but this duty is carried out by all staff on a rotational basis and they never employed agency staff. We looked at the staffing rota for the previous three weeks which confirmed the staffing numbers were the same as stated by the registered provider although the area manager, registered manager and assistant manager were not on the rota for the weekend which might account for the comment we received about less staff at the

weekend.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, a review of people's employment history and two references received for each person. DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

As part of our inspection process we checked to see whether medicines were ordered, stored and administered safely. There were minor improvements required to the administration of medicines. For example, body maps were not used to direct staff to where to apply creams, handwritten Medicines Administration Records had not been signed by two members of staff and the administration of one person's eye drops did not detail which eye or whether both eyes required the drop. The window to the medicines room could be opened wide which meant it was not secure from an intruder although this was rectified immediately by the registered provider who installed a restrictor. We had some concerns regarding crushed medicines, which the GP had advised was acceptable without a clear indication from a pharmacist that this did not affect the efficacy of the medication or pose a risk to the people using it.

We found the environment to be clean and hygienic. One relative said about the premises "They are clean and hygienic compared to some other (homes) we had seen. They have put new carpets into the lounge recently." Another relative said, "It's a little grubby and a bit of a drab environment". We observed the service had recently purchased new chairs in addition to the new carpet and had a planned programme of renovations to upgrade the home.

Requires Improvement

Is the service effective?

Our findings

We asked people whether they enjoyed their meals at Stella House. People were complimentary about the food and said, "The food is very nice. I get a choice. I eat in my own room", "The food is really good....nice....appetising", "The food is really nice, although there is no salt to put on the food when I eat in my own room" and "Food is very good and we get a choice". When asked if they were able to get drinks and snacks at any time one person told us, "You only have to say you want something and they get it for you."

We observed lunch time in the dining room which was clean and spacious. Sixteen people were seated at tables, set with cutlery, napkins, glasses and condiments. Music was playing and the atmosphere was pleasant. Six care staff were in the room at various times and two people required full support to eat their meal. People were offered a choice of main course and dessert. One person who was not eating very much, was asked if they would prefer an alternative. They were immediately provided with an alternative which they preferred. Several people were offered, and accepted, clothes protectors. Lunch was unhurried and people were able to eat at their own pace and care staff encouraged people to eat, without being overbearing

We observed people receiving tea, coffee and biscuits during the inspection. In addition a choice of soft drinks was available to people in lounges or in their bedrooms. We witnessed one person who did not want a drink but was left with a plastic beaker and who was encouraged at various times during the day to take a drink as it was a hot and humid day. People who required their fluid and nutrition intake to be monitored had a food and fluid intake chart. We saw this was completed at each meal although staff were not consistently filling in the diagram to evidence what portion of food had been eaten. We raised this with the registered provider who told us they would reinforce to staff the importance of completing these correctly and ensure the team leader on each shift monitored this to ensure there was no confusion as to people's actual nutritional and hydration intake.

The registered provider and area manager told us they would be changing their system of meal preparation to a catering company which provided nutritionally balanced meals and a varied menu choice. A tasting session had been planned for people using the service, relatives and staff to try out the meals to assist with planning the menu to the preferences of the people who lived there.

People received care and support from staff who knew them well and who had the skills and training to meet their needs. Staff confirmed they undertook a thorough induction when they first started working in the home and we saw this was evidenced in the staff files we reviewed. Staff completed the Care Certificate and the registered manager was the assessor for the certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. Staff were given an exercise when they first started working at the home called "Getting to know the team", where they had to seek information on the roles within the home and were provided with safety aspects such as where the fire exists were and policies and procedures. This

showed that the service had a system in place to ensure staff were inducted into their role.

The home utilised an external training provider to support staff development. We looked at the training matrix and could see the records of training showed us a range of learning opportunities were provided for all staff. This included mandatory training in safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards, moving and handling of people, equality and diversity, fire, health and safety and infection control. Additional training had been provided around dementia, nutrition, pressure area care and end of life care. The home had introduced a comprehensive moving and handling competency check list for staff to ensure following the receipt of training they could put this knowledge into practice and had the skills to handle people safely.

Care staff told us they had received regular supervision and we saw evidence to support staff were regularly supervised and received an annual appraisal. Regular supervision of staff is essential to ensure the people at the home are provided with the highest standard of care. The assistant manager told us they had not had any recent supervision with the registered manager, but said "We talk all the time. We talk every day." Formal recorded supervision for all staff is essential, even if staff do not feel they require supervision and staff at all levels are required to reflect on their practice to enable them to continually improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS.) 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. At the time of our inspection 25 DoLS applications for authorisations had been sent to the local authority, and nine had been approved. In the care files we reviewed we checked whether any conditions on authorisation had been met, but there had been no conditions attached. The home assessed people against a Deprivation of Liberty check list to determine whether the person had their liberty restricted. This guided the assessor to identify when a person was at risk of having their liberty deprived and when a referral to the authorising body was required.

During our inspection we reviewed the capacity section in the care files of four people to ensure they were compliant with the MCA. The two stage capacity assessment had been completed correctly in relation to the deprivation of liberty but there were no other decision specific capacity assessments or best interest decisions. This meant the home had not met the requirements of the MCA. This was particularly important as there were a number of people cared for in bed and the home needed to demonstrate this was in their best interests and there was not a least restrictive option such as the provision of specialist seating systems to enable the person to be cared for out of bed. There were no decision specific capacity assessments in relation to medicines. These issues were raised with the area manager at inspection, who advised us they would attend to this immediately. This lack of recorded capacity assessment and best interest decision making was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast the staff were provided with detailed information in the capacity section of people's care files to

support people to make their own decisions where people had cognitive impairments but could make decisions for themselves with support. We found the staff at the service we spoke with had a good understanding around mental capacity to consent to care and they could tell us how they supported decision making in everyday life to maximise people's understanding and choice in activities such as getting dressed. One member of staff told us if the person lacked capacity and they were supporting the person to dress, they would choose appropriate clothes for the person to show them the suitable options and support them to choose.

We found in four care files we reviewed that relatives and staff had consented on behalf of people when there was no evidence of legal authority to do so either with a lasting power of attorney (LPA) or a Court of Protection authority. However, this omission had been recognised before our inspection and relatives had been written to for confirmation of their legal status to consent on behalf of others. However, this was a breach of Regulation 11 of the Health and Social Care Act of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had not always acted with lawful consent.

People told us they could get access to their own GP when necessary and also had input from other professionals such as a chiropodist and a hairdresser. The area manager told us they referred to Mid Yorkshire Therapies if a person required a dietician, physiotherapy or Occupational Therapist.

The area manager told us they were planning to improve the environment to be more dementia friendly with wall coverings and signage. They told us Dementia Care Mappers would be coming to assess the home once they had completed this at one of the registered provider's other homes. Dementia Care Mapping™ is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence. The home had ramped access to the front and an enclosed garden to the rear. Access between floors was provided by a through floor lift and stairlift. The home was accessible in a wheelchair although one person told us they struggled to push their relation over the wooden threshold at the front door.

Good

Is the service caring?

Our findings

People living at the service told us they were well cared for and told us staff were helpful and effective. One resident said "would prefer to be at home but I am well looked after by the staff". When asked if they felt staff cared for them, people we spoke with said "yes". Comments included, "Yes. This place is as good as anywhere" and "They try hard but they are not nurses so you cannot expect too much."

We observed care interactions. Staff were polite and sensitive to people's needs and we observed people were comfortable in the presence of staff. We saw people were appropriately supported with their lunch when required and this was done in a caring and dignified way. We observed staff speaking gently with people and introducing themselves by name. Staff were monitored on how they supported people with dignity to ensure the service continued to maintain a high standard with this aspect of care provision. People we spoke with told us staff maintained their privacy and dignity in the home. This included ensuring all personal care was provided in private, ensuring people were covered during personal care and curtains drawn and doors closed. The area manager told us they had identified staff calling people "sweetheart" and they discussed the negative and positives of this with the person. They told us they did not promote a culture where this is used in common language but looked at it from a position of what is acceptable to the person supported. This showed that the registered provider was ensuring a culture where dignity was respected.

The area manager told us they supported people to remain independent and improve their independence. They told us of two recent examples to demonstrate this. The first example, was , where one person had come to the home cared for in bed but within 3-4 weeks with care and encouragement had taken a few steps and was now going home with a package of care. A second person had been admitted following an infection which had temporarily reduced their abilities but following the period of recuperation and with the encouragement of the staff, they had increased their abilities and had returned home the day before our inspection.

People's abilities were recorded in their care plans. We saw records such as "[name] is able to wash [their] face, hands and upper body but will need assistance from staff in other areas." And "[Name] has their own teeth and will brush them independently once staff have put toothpaste on toothbrush." This meant staff were encouraging people to remain as independent as possible during personal care activities.

We saw evidence people had been referred appropriately to advocates such as an Independent Mental Capacity Advocate (IMCA). The IMCA role is to support and represent the person in the decision-making process if they lack the capacity to make decisions on their own.

Friends and relatives told us they were able to visit at any time and said they felt welcome. One person who received regular visits told us, "I got a bigger room so that it is easier for relatives to visit me. I was very pleased with that."

Requires Improvement

Is the service responsive?

Our findings

The area manager told us they ensured the service provided person centred care by ensuring staff "worked together with individuals to deliver the things that are important to them, and their choice and preference." They told us, "People are offered choice. It's not about working around them. They can choose what time they want to go to bed, get up, which lounge to sit in, whether they want to go into the garden." Relatives said they felt involved in decisions about the health and welfare of their relation. We observed choice being offered to people throughout the day including where they wanted to sit to eat, and what they wanted to eat and drink. We saw bedrooms had been personalised with family photographs, small items of furniture and ornaments.

As part of our inspection process, we observed how Stella House ensured the mental wellbeing of the people who lived there through the provision of meaningful occupation throughout the day. Stella House employed an activities co-ordinator between 8 am and 3 pm 3-4 days a week. They were new into the post and were very enthusiastic about improving the level of activity for people. A monthly programme of activities was posted on a notice in the communal lounges. Daily activities were on offer for the month of August and included a trip to a local stately home, the local market, and a visit from Zoolab. Zoolab utilises pet therapy animals to enhance wellbeing in the care home setting. The area manager told us relatives were also invited to the day trip to the stately home. A hairdresser visited the home each week and we questioned the activities coordinator about the relevance of this for all people at the home as an activity, and they told us that on such days ad-hoc activities would take place such as games of skittles or a quiz.

The trips out were funded from donations and fund-raising activities and transport provided by the local authority. People were asked for feedback following any activities to ensure the service provided activities people wanted to do. Positive comments had been received from residents and their relatives. We were told people who liked to stay in their room were offered individual activities such as manicures, looking and talking with people about their family photographs and ensuring they had access to new magazines and other reading materials. We noted in the lounge areas there was a reminiscence journal called "Weekly Sparkle" to promote discussions with people at the home. It included articles, quizzes and recollection of past events and trivia. The journal was out of date (1st – 7th August) but we were told by the activities coordinator that future editions would be printed and be available for people to enjoy.

We saw the Stella House July newsletter titled 'What have we been up to in July at Stella House." This recorded what activities had taken place throughout July, such as a fundraising event on 23 July 2016 to raise funds for resident activities. It also recorded a computer console had been purchased to motivate people to exercise, and a popcorn machine for Sunday movie night. It also referred to a tuck shop every Tuesday with people living at the home able to request a preference for what would be stocked. The newsletter requested people and their relatives make suggestions for activities and put these in the suggestion box at the entrance of the home. This demonstrated the home was acting on the views of people using the service to improve this aspect of care and wellbeing at Stella House.

The relatives we spoke to were aware there were relative meetings at Stella House to enable them to be involved and share their views on the service provided. One of the relatives told us they had been to the occasional meeting and another said "I visit nearly every day so if there are any issues I can speak about them, there and then. So, I do not need to go to the meetings".

At our previous inspection we found a lack of person centred recording in the care files of people using the service. This had significantly improved and the majority of care plans were detailed and included person centred information to enable staff to care for people in a way the person would choose to have their care provided. Even though recorded capacity assessments had not been completed there was a section in each file which advised staff how best to support people to make decisions in their everyday lives. All the care plans of people living at the home had recently been reviewed and we found some minor gaps in recording such as not all sections being completed fully. Records were reviewed on a monthly basis to ensure information was updated as required when people's needs had changed. This meant those people were provided with care that met their changing needs.

We found an improvement in daily record keeping at the service. These were completed several times each day giving a chronology of the person's day. Some of the records were very detailed evidencing people had been offered choice in their daily lives and others were more task focussed. However, we found an issue with one person who had been staying on a temporary basis and whose care plan had not been completed fully. This person had complex needs and this information should have been recorded in a plan of care to ensure risks had been fully explored and reduced, equipment had been assessed as suitable to meet their needs and support plans reflected the care provided. We were told by the area manager they had identified the issue with respite care plans, as these people had not been aligned to a key person responsible to update these. We reviewed the daily records for this person which demonstrated staff were appropriately meeting their needs. However, this demonstrated a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home had not maintained an accurate, complete and contemporaneous record including decisions taken in relation to the care and treatment provided.

We observed the handover at the service which evidenced staff were informing staff on the following shift how the person had been during the previous staff shift to enable staff to continue to support the person and meet their needs which might have changed from the last time staff had supported the person.

We asked one member of staff how they would deal with a complaint if they received one. They told us it would depend what the complaint was about. They told us a relative had complained informally about the new coffee tables which their relation could not reach as it was too low. They told us this information was passed on to the owner who dealt with this informally. We asked people at the service whether they knew who to complain to if they were unhappy with the service. People told us they could express their opinions and that any problems would be acted upon. None of the people we spoke with said they had made a complaint. We were aware of a complaint made by a person's relative who no longer lived at the home and this had progressed through the formal complaints process in line with the company policy. We were shown recent compliments received from relatives. One thanked the staff for the love and care shown to their relation who died peacefully with dignity and for welcoming the relatives at any time.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had been registered since July 2015 although had been in post as manager at the time of our last inspection. They were not at the service during our inspection and the area manager was temporarily at the home providing management support to the staff.

All the people we spoke with and their relatives told us they could approach and talk to senior staff about any problems. We observed staff and managers interacted well with people living at the service and their relatives. The assistant manager described the culture as "Warm, welcoming and homely. That's what people comment on. Staff are smashing. They will do anything for anybody and are really supporting. If you read the cards from people it will tell you. I am proud to say I work at Stella House." The registered provider confirmed this. They also said, "We are a lot more responsive from findings (such as inspections) than we used to be. Staff are really eager to learn and are knowledgeable".

As part of our inspection process we looked to see whether audit and quality assurance systems had been effective in identifying and addressing problems. The area manager showed us the Stella House Quality assurance report dated June 2016. This report collated information from feedback questionnaires, CQC inspection and internal and external inspections. There had been a 57.5% return rate of questionnaires with all positive comments recorded. One person had been unhappy with the care provided although the report did not detail the information to demonstrate whether the service had taken action or learnt from this negative experience. However, there was a section within the report titled "Recommendations and suggestions for improvements" with responses and actions to all comments received, what the home was doing about these comments with a time frame for action.

Regular audits were completed at the home to monitor the quality of the service provided and these were completed by the senior staff, the registered manager and the registered provider. We saw evidence of a care plan audit which looked at daily entries of staff to ensure records were recorded in a person centred way, and care needs were documented and checked for family involvement. These audits were extremely detailed where completed but had not identified the issue we found with incomplete respite care plans or lack of detail in the moving and handling care plans.

We saw an audit of food and fluid charts and where these had highlighted missing entries or incomplete entries, this information had been cascaded to the team leaders to improve the recording practice of staff and checking processes. We saw records of a lunchtime observation on 16 and 18 August 2016 to ensure the lunchtime experience was positive. Any areas for improvement had been discussed with staff and the actions had been recorded from 16 August 2016.

The service had implemented safety checks on the building each night to ensure the building was safe and secure and people at the service were safe. We saw records of the checks completed between 1 and 14 August 2016 and staff had signed these had been completed but no records were available during the inspection to confirm these had been completed the week prior to the inspection. There was a daily

management checklist to complete in relation to the environment, with details of further actions required if an issue was highlighted, but the latest record we were shown was dated 9 August 2016. The registered provider should ensure these checks are undertaken and recorded as part of the new management arrangements to evidence this aspect of quality management.

In addition to these safety checks, systems and processes had been changed to ensure people did not enter or leave the building without staff awareness as prior to the inspection we had been notified two people had left the building when it was not considered safe to do so. We were shown details of all the measures that had been put in place to resolve this. However, following completion of the inspection we were notified that one of the people who had previously left the building had done so again on 13 September 2016 and an investigation was on-going to determine how this had happened. This demonstrated the systems and processes put in place from the previous incident had not been effective. This was a breach of Regulation 17 (2) (b) as systems and processes had failed to assess, monitor and mitigate the risk to the health, safety and wellbeing of people who used the service.

We saw a service user quality assurance management audit where people had been asked for their experience of care using the key lines of enquiries; safe, effective, caring, responsive and well-led and another dated 04 August 2016. Two people had made negative comments and we saw evidence this had been explored and acted upon.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We saw evidence that various staff meetings were held with the different staff groups at the home. All meetings had recorded minutes which evidenced the discussions, although they did not contain an action section which would have been helpful to ensure actions were completed between meetings. We were shown the minutes of the latest meeting held for domestic staff on 10 August 2016 and a joint team leader/domestic meeting held on 12 July 2016. Items discussed were inappropriate bagging of soiled items, correct use of tumble dryers, completion of accident and incident forms and laundry issues.

We saw evidence the registered manager and area manager had a management meeting with all their registered homes to discuss management issues and monitor the quality of the service and where improvements were required. At a meeting held on 15 April 2016 Key aspects of the Care Quality Commissions standards were discussed along with the Deprivation of Liberty Safeguards and end of life care. Staff were reminded to ensure they were working to the current NICE guidelines when writing policies. This showed the management team were considering best practice in the running of their service.

The service recorded all accidents and incidents and these were collated on an accident and incident analysis form. The registered manager reviewed this information each month but we found the analysis was not detailed to evidence actions had been put in place to reduce further incidents. We identified one person who had been highlighted as having several incidents and cross referenced this with their care file and daily record. We could see actions had been taken to resolve the issue, but this information had not been readily available. We discussed this with the registered provider who would ensure the analysis and recording of prevention of future incidents improved.

We saw the minutes of the relatives meeting held on 12 May 2016. People at the service had been asked their view on upcoming events, and how to improve the service they offered. People had said they would like music rather than the television in an afternoon and a wider selection of reading material and magazines. They also requested fresh fruit on offer with the tea trolley in addition to biscuits, buns and cakes. We saw

these requests had been actioned during our inspection.

The area manager told us they were to register to the Social Care Commitment. The Social Care Commitment is a promise made by people who work in social care to give the best care and support they can. It was created as a very practical way to improve standards. It is also seen as a key way of increasing the public's confidence in social care services. In addition to this Stella House planned to utilise Dementia Care Mapping to achieve and embed person-centred care for people with dementia

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 11 HSCA RA Regulations 2014 Need for consent Staff consented on behalf of people without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess the health and safety of people using services and have plans in place for managing risk.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of recorded decision specific capacity assessments. Lack of care plans in place for one person on respite care. Lack of recorded risk assessment and associated measures for the person on respite care. Failure to assess, monitor and mitigate the risk in relation to the health, safety and welfare of people who had left the premises without staff being aware, when it was not safe for them to do so.

The enforcement action we took:

Warning notice against Regulation 17 of the HSCA Regulations 2008 (Regulated Activities) Regulations 2014
Lack of recorded decision specific capacity assessments.
Lack of care plans in place for one person on respite care.
Lack of recorded risk assessment and associated measures for the person on respite care.