Weatherstones House Care Limited

Weatherstones House Nursing Home

Inspection report

Chester High Road
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Cheshire
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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 care service is owned by Weatherstones House Care Limited.
Weatherstones Nursing Home is a large sandstone detached property in two acres of grounds. It is situated on the A540 close to the village of Willaston and the town of Neston. The home has 24 bedrooms, 15 of which have en-suite facilities. There are two floors with a passenger lift and staircase.

The service had a registered manager who was registered with us in 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was present during the days of our visit.

On our last visit, we rated the service as good. This inspection found that overall the service remains good.

Staff understood the types of abuse that could occur and measures were in place to ensure that people who used the service were protected.

Staffing levels were appropriate to meet people's needs.

Medication management was robust with medicines appropriately stored and accounted for, however improvements were needed to make medication administration more person-centred. These steps have subsequently been taken.

Recruitment procedures included checks on new staff to ensure that they were suitable to support vulnerable people.

The premises were well maintained and all checks on equipment such as portable hoists or electrical equipment had been made.

Staff received the training and supervision they required to perform their role. A structured induction process was in place for new staff.

The registered provider had demonstrated a clear process for determining people's capacity in line with the principles of the Mental Capacity Act 2005.

Signage had been put into place for one person living with dementia. This assisted in orientating this person around the building.

The nutritional needs of people were met. People were referred to other health professionals in order to

promote their wellbeing.

People were supported in a kind and patient manner. Staff ensured that people's privacy and dignity was upheld at all times. People were enabled to be as independent as possible and have their wishes respected.

Care plans were in place. These were reviewed and include key information about each person. Care plans included reference to the preference, likes and dislikes people had and how they wished to pursue daily routines.

Activities were provided and subsequent action has been taken to ensure that this was person centred.

A complaints procedure was in place. No complaints had been received but people felt confident that their views would be listened to.

People commented that the service was "home-like" and staff considered the culture of the registered manager to be supportive and approachable.

People had the opportunity to express their views about the support they received and these were positive.

Audits were in place to measure the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Weatherstones House Nursing 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.

The inspection took place on the 28th September and 2nd October 2018.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has experience of caring for someone who uses this type of care service.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. In addition to this we spoke with five people who used the service and one relative. We also spoke with the registered manager, deputy manager and four members of staff. We spoke with members of the local authority commissioning team who had no concerns about the service.

As part of our inspection, we ask registered providers to complete 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. This information was used as part of our assessment of the service. A PIR was returned to us when we asked.

We checked to see if there had been a recent visit from Healthwatch. Healthwatch is an independent consumer champion created to gather and represent the views of the public. Healthwatch visited the service in July 2018. No concerns were raised during this visit.

Good

Is the service safe?

Our findings

Staff were clear about the types of abuse that could arise. They were also clear about the action they would take if they witnessed or were made aware of any alleged abuse. The registered provider had a clear reporting process in place to make other agencies aware of any incidents and staff were confident that the registered manager would pass any concerns on. Staff were clear about the agencies they could speak with if they had any concerns about care practice within the home. They were aware that they could contact CQC.

The registered manager had systems in place to report any low-level concerns on a monthly basis. Low level concerns are those incidents which do not meet the threshold for a more formal investigation. The service had not needed to report any safeguarding issues to us since our last inspection visit.

Everyone told us that they "felt safe" and had no concerns about any aspects of safety or security.

Staff recruitment was robust. This meant that people who used the service could be confident that they would be supported by staff who were suitable to support vulnerable people. Recruitment files included appropriate checks on the person including references, a disclosure and barring check (known as a DBS) and information confirming the identify of each new person.

Staff rotas were in place outlining the numbers of any staff on duty at any time during the day and night. During our visit there were sufficient staff available to respond to the needs of people. People told us "There's always someone around". Staff included nursing and care staff who could attend to the needs of people; whilst ancillary staff such as kitchen and domestic staff were also available. Staff told us that at present they felt there were enough staff to meet the needs of people. Other staff were employed including maintenance staff and an activities co-ordinator. The activities co-ordinator worked each afternoon to provide activities to people who wished to participate.

Medication was managed appropriately. All medication was stored securely. Some people had been prescribed controlled medicines. These are items which are subject to strict legal controls. These were securely stored. An accompanying register was in place outlining stock checks and when this medication had been given. We checked the stock levels against the register and found that they tallied. Temperature records were in place for the medication room as well as the medication refrigerator. This ensured that all medicines that required to be stored at a certain temperature could be as effective as possible.

Medication administration records were maintained (known as MARS). These showed details of when medicines had been received, how much medication had been received and signatures to confirm that they had been administered. All MARS were signed appropriately. A system for the disposal of unwanted medication was in place. This included records of those medicines returned to the pharmacy supplier.

An audit of weekly stock checks was maintained and this included an assessment of whether records relating to medicines had been appropriately signed. Only one person administered their own medicines,

however staff always watched to ensure it was taken. Everyone told us they were receiving their medicines at the correct time.

Risk assessments were in place. These outlined the potential hazards faced by people in the support they received, their health needs and risks from the wider environment. Risk assessments were in place for those who were susceptible to pressure ulcers, falls and malnutrition. All risk assessments were up to date and evaluated monthly.

The premises were well maintained. The registered provider employed maintenance staff who was attending to repairs and decoration during our visit. Records were maintained outlining those maintenance jobs that needed doing and a date for when they had been completed. Equipment such as portable hoists and electrical appliances had been checked appropriately.

Furniture and fittings were of a good standard. The registered manager confirmed that there had been a recent ongoing programme to replace chairs and tables within the building. Attention had been made to ensure that these were to a good standard and were suitable to the needs of people who used the service. Refurbishment of the building was ongoing with maintenance staff attending to areas that needed decorating. We noted that upstairs carpets appeared stained yet we were provided with evidence that new carpets were to be fitted in the near future.

The premises were clean and hygienic. Domestic staff were employed by the registered provider and they were seen attending to their tasks. Domestic staff used personal protective equipment (known as PPE) such as disposable aprons and gloves to minimise the risk of infection spreading. A rota had been devised for the deep cleaning of certain areas such as lounges, bathrooms and bedrooms to ensure hygiene standards were maintained. These checks formed part of an infection control audits utilised by the registered manager.

Accidents and incidents were reported appropriately. These were analysed to identify any trends or patterns with a view to minimise future occurrence.

Good

Is the service effective?

Our findings

People commented on how knowledgeable the staff team were about their needs. This ranged from individual preferences in their daily lives to the general "nice" approach that staff had in supporting them. People told us "They [staff] know me so well".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff had received training in the Mental Capacity Act 2015 and were able to outline the broad principles of this and how this impacted on the daily lives of people.

initially it was concluded that the registered provider was not always operating within the principles of the mental capacity act. Care plans included general terms about people "lacking capacity" but there was at the time no assessment or evidence as to how this had been assessed.
Subsequent evidence provided to us by the registered provider found that a robust process for determining capacity was in place. Deprivation of liberty safeguard applications had been sent to the Local Authority with a view to protect people from harm.

We looked at whether the environment was friendly to those living with dementia. Steps had been taken in respect of one person to assist them to be orientated to their environment. This had been done with the provision of signage in the person's living area.

We looked at how the nutritional needs of people were met. Meals were prepared in a well-equipped and organised kitchen. The kitchen had received a five-star hygiene rating from the local authority in May 2018. This is the maximum rating that can be achieved. The kitchen included information on the nutritional needs of people, for example, how their meals should be presented and an indication of their preferences. People were generally complimentary of the meals provided. People told us, "The food is very good and there is always plenty of it", "It is very good especially the puddings" and "The food is good here but there could be more variety".

The preference of people for meals were gained verbally from each person during the morning prior to lunch. A written menu was on display in the hallway and this was supplemented by pictorial menus. Alternatives and choices were available to people.

We observed lunch on the first day of our visit. Staff sought to attend to the needs of people and interacted with people in a friendly and helpful manner. Staff were also aware of the preferences of people. People were encouraged to eat independently and were assistance was required, this was provided appropriately. We did observe that a person using a wheelchair did have some difficulty in sitting at a table and as a result could not fully get close to the table. We were advised that new tables had been purchased to enable people using wheelchairs to come as close to the table as possible and it was suggested that these were introduced into the dining room.

People had their weights monitored on a regular basis. There was evidence that where weight loss had been a concern that this had been promptly referred to a GP. There was evidence that people who had come to live at the service and had experienced weight loss had increased their weights and this had had a positive impact on their health and wellbeing.

We recommend that the registered provider refers to good practice guidelines in relation to the environmental considerations for those people living with dementia.

We looked at how the service promoted and maintained the health of people who used the service. A local GP visited the service on a weekly basis and had done for some time. We spoke with the GP who told us "It is a good service with a strong emphasis on continuity of care", "Staff are knowledgeable about people's needs" and "I have a good working relationship with the staff team". The main health needs of people were included within care plans and details were in place to work towards alleviating ailments as much as possible. The nursing staff compiled an ongoing account of the health of each person with a view to referring them to the GP. Once a visit had been undertaken; appropriate changes to medication, for example, or care plans were made. Other records were in place reflecting the input of other professionals, for example, opticians and physiotherapists. One person told us "The GP visits to me whether I am ill or not".

Staff received the training and supervision they required to perform their role. Where new staff had come to work at the service, an induction process was available to enable them to become familiar with their role. Where staff had not had previous experience in supporting people, the care certificate was available to enable them to do this. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme.

Good

Is the service caring?

Our findings

People were very positive about the approach used by the staff team. People told us "I feel as if they [staff] take really good care of me", "They [staff] are wonderful" and "They are funny and caring at the same time- we laugh a lot".

Our observations noted that staff respected people and interacted with them in a patient and kind manner. Staff were seen to knock on doors before being invited to enter and always asked people if they needed any assistance. People told us that they were able to make their own decisions about their daily lives and we saw staff offering people a meaningful choice in what they wanted to do or where they wanted to sit, for example. People told us that they could receive visitors in private. Relatives told us that they were made to feel welcome by the staff and felt that it was like an "extended" family.

Staff gave us examples of how they promoted people's privacy, especially during support with personal care. This involved practical measures such as ensuring that doors and curtains were closed and that people were covered up to preserve their dignity. Our observations also noted that people were well groomed and presented with staff paying attention to little details about people's appearance.

Confidential information was kept secure at all times. This ensured that sensitive information relating to people's personal needs and details were only available to those who were involved with people's care and support.

Compliments had been received by the service. These included comments such as "Thank you for all your care and support", "I can certainly recommend Weatherstones" and "Thank you for all you have done for us". All compliments were on display enabling staff to refer to.

The registered provider recorded any cultural or spiritual needs of people in care plans. People told us that they felt as though these needs were being met and were not overlooked. People had religious needs were of the same religious denomination. Services were held each month within the service and proved popular with the people who lived there.

The wishes of people when considering coming to the end of their lives had been taken into account. These included specific arrangements they wanted in place to meet their wishes or their religious needs. Other arrangements had been put into place as to whether people wished to be resuscitated and these were reflected in DNAR (don not attempt resuscitation) forms available for some people.

Bedrooms had been personalised in line with people's tastes. People we spoke with were happy with their bedrooms and in many cases, people had filled their rooms with personal items such as photographs or furniture in order for them to impress their identity on their living space.

Good

Is the service responsive?

Our findings

An activities co-ordinator was employed by the registered provider and this person worked each afternoon. No fixed activities plan was in place as the co-ordinator sought to be flexible with in-house activities and focus on the preferences of people on any given day. Entertainers from outside of the home visited and trips to local places of interest had also taken place. A church service was held each month and people told us this was appreciated and well attended.

During our visit some people were playing a board game, another read magazines and another person received a one to one chat with a member of staff. People had mixed views about the activities provided. They told us that while they were informed of what activity was being held each day; some people told us that they did not like the activities at the service and would not take part "I am not particularly interested in activities and "I am not a fan of bingo". A view was formed that while activities were enjoyed by some people; this did not extend to all. We noted also that people who were confined to their beds because of health reasons were offered limited activities. Subsequent to our visit, the registered manager advised that steps had been taken to provide a more person centred approach to the provision of activities.

Prior to people coming to use the service, an assessment of their needs was completed by the staff team. This was used in conjunction with any other assessments gained from the local authority or other agencies. Assessments included all aspects of the needs people had in their daily lives to be supported successfully. Details included their medical needs, social interests and communication needs. Information included risks that people had faced from falls, malnutrition and pressure ulcers.

Once completed, assessments were translated into care plans. Each person using the service at the time of our visit had a care plan. All care plans were person centred and included details of the support people required in all aspects of their daily lives where applicable. In some cases, people were independent in certain daily routines and were encouraged to continue with these. The person-centred nature of care plans was reflected in details of the individual preferences, likes and dislikes of people and ways in which they wished to be supported. People told us "They [staff] know what I like and what I don't" and "They [staff] know me well".

While care plans were person centred, initially some elements in respect of supporting people with medication were considered as needing further development. Subsequent action taken by the registered manager evidenced a more person centred approach to this.Nursing staff had been provided with information in care plans relating to the administration of medication and this stated the need to "adhere to NMC guidelines" (The NMC is the regulatory body for nurses) or "adhere to the service's procedure". A "This Is Me" document provided evidence of a person centred approach in respect of medication administration.

We looked at how the service made information accessible to people who used the service. Care plans included details of whether people relied on aids to assist with them being able to receive information appropriately such as glasses or hearing aids. People who required these were provided with them.

Information was provided to people verbally but also in pictorial form. A written menu, for example, was available in the main hallway and it was unclear whether this was the only way that this information was presented to people. The registered manager provided evidence that menus were also available in pictorial form if needed. Activities offered were on display with an activities board. This included photographs of previously held activities.

A complaints procedure was available. No complaints had been received by the registered. provider. The procedure outlined the timescales for concerns and complaints to be responded to. People told us that they would feel confident about raising concerns and that they would be listened to.

While no one was at the end stage of their lives during our visit, the service had arrangements in place through weekly visits by a GP to focus on the palliative care needs of people if they arose and to respond if necessary.

Good

Is the service well-led?

Our findings

People told us that they were aware of who the registered manager was. They told us "She is very nice and approachable" and "If I had a problem she would definitely listen". People had a positive view of the culture within the service and considered the service to be "homely". This was reflected by the staff team who considered the registered manager to be supportive and approachable.

The registered manager had been in post since 2014. A deputy manager was also part of the management team and this person was clinical lead for the service.

The views of people who used the service was gained through annual surveys as well as daily contact with them. The results of surveys were available and all outcomes were positive. In addition to this, relatives/residents' meetings were held and these outlined the views of people as well as identifying their preferences within the service. A suggestion box was available in the main hallway and people were invited to comment on the support provided. All comments received were positive.

Audits were undertaken. These extended to medication, the environment and care plans. It was noted that the capacity assessments were not always present within care plans which questioned the robustness of the auditing process of this. The registered manager was aware of the needs of the people who used the service

The registered provider had regular contact with the service. The registered manager confirmed that a representative of the registered provider visited and had listened to the registered manager's plans for developing the service; in particular the need to refurbish fixtures and fittings within the building.

The registered provider always informed us of any incidents that adversely affected the wellbeing of people. A requirement of registered providers is that the rating from the last inspection is put on prominently display. This had been done.

Policies and procedures were in place outlining the key ethos of the service and the approach the registered provider would take, for example, in protecting people form abuse, medication administration and recruitment. All policies were up to date and enabled staff to be guided into the areas of good practice.

The registered manager sought to liaise with other professionals. These included social workers and the local GP who had regular contact with the service. This latter relationship worked well in enabling the health of people to be promoted.