Care Quality Commission

Saffron Healthcare Limited

Stanley Wilson Lodge

Inspection report

Four Acres
Saffron Walden
Essex
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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection took place on the 8 December 2014.

Stanley Wilson Lodge provides accommodation on three separate floors. The ground floor is residential, the middle floor is for people living with dementia and the top floor is for people with nursing needs. The home can accommodate up to 75 people. On the day of our inspection the home was fully occupied.

There was a registered manager in post. 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 and associated regulations about how the service is run.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions for themselves and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

Summary of findings

The staff were acting lawfully and had a good understanding of relevant legislation and how to support people who did not have capacity to make decisions about their own care and welfare.

Staff knew what actions to take if they suspected someone to be at risk from abuse or harm. This meant as far as possible people could be protected.

People were adequately supported and kept safe but there were not always enough staff to respond to people's needs adequately.

People's health care needs were met but we identified inconsistent practices around recording so could not be assured that people's needs in relation to their health and welfare were met accurately.

The home provided sufficient emotional and social stimulation for people with a range of activities and links with the community to help people stay in touch with their pasts.

There was an effective complaints procedure and people and their families were encouraged to give feedback about the care provided. This enabled the manager to address any concerns when they arouse.

The service was well managed, and there was an open, positive culture. People's rights were promoted and risks to people's safety were monitored to ensure as far as possible these were reduced.

Summary of findings

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 was not always safe.

Staffing levels were not always sufficient to meet people's needs.

Medicine practices had improved and we were confident people got their medicines safely. Staff were adequately trained and supervised. There were systems in place to identify any medicine errors so these could be rectified.

Staff were familiar with people's needs and knew what actions to take to protect people from abuse.

Systems were in place to ensure people were cared for in a safe environment and risks to people's safety were as far as possible reduced.

Requires Improvement

Is the service effective?
The service was not effective.

Records did not adequately demonstrate that everyone got enough to eat and drink for their needs so we could not be assured their needs were met.

Care staff were well supported and received enough supervision and training to help them do their job competently.

People were supported to make decisions for themselves and where they were unable to do so the staff worked within the requirements of the legislation to ensure people were supported and protected.

Requires Improvement

Is the service caring?
The service was caring.

Staff treated people respectfully, were familiar with their needs and were able to diffuse potentially difficult situations by staying calm and effectively supporting people.

Family members were as involved as they wanted to be in their family member's care.

Good

Is the service responsive?
The service was responsive.

The service worked with other agencies, the local community and family members to meet people's needs.

People's needs were assessed and kept under review.

People were confident with the way complaints were managed and there were systems in place to consult with people about the service they received so improvements could be identified.

Good

Summary of findings

There was a programme of activities to suit people's individual needs and preferences and to provide mental stimulation to people.

Is the service well-led?

Good

The service was well led.

The registered manager worked inclusively and was trusted by her staff. They also felt well supported in their role.

Staff turn- over was low and there were systems in place to develop and support staff.

There were systems in place to continuously monitor and evaluate the service to identify what improvements were necessary.

Stanley Wilson Lodge

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 8 December 2014 and was unannounced. The inspection was undertaken by two 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. Our expert had experience of dementia care.

Before the inspection we analysed information we already held about this service which included any notifications and share your experience forms. A notification is information about important events which the service is required to send to us by law. We reviewed the provider information return, (PIR) which is a form we ask all providers to complete to tell us how they are managing their service.

We spent most of the day of our inspection observing the care provided to people on each of the three units. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with fifteen residents, six visitors and twelve staff including senior staff, care staff, activity staff and ancillary staff. We looked at four care plans and other records relating to the management of the business.

Requires Improvement

Is the service safe?

Our findings

We received contradictory feedback about staffing levels in the home which made it difficult for us to assess if there were enough staff to meet people's assessed needs. Some people told us there were enough staff, others disagreed. One person said, "There's always someone around, "but their visitor said "They have told me they are short staffed." Another person told us that when staff helped them to mobilise using the hoist, "It was all done in a bit of a hurry."

We recognised that on the day of our inspection the home was very busy. A number of people were poorly, there was an emergency incident that had to be managed and we saw many different activities going on. The manager told us that they were 'overstaffed' and did not have any staffing vacancies. The staffing rotas showed us that the home had the number of staff on duty that were required, according to people's assessed needs. People's dependency levels were kept under review to help the manager determine the right staffing levels. However we felt staffing levels were not appropriate for people's needs because of what we observed on the day.

We carried out observations on each of the floors to assess if people had their needs met and received safe care. Before lunch we observed people in the dementia care unit for over two hours. Some people had gone downstairs to hear the school children sing, others were being assisted up and the nurse was seeing people who were poorly. The people in the main lounge were not regularly supervised and we observed minor altercations between different people. On a number of occasions we assisted people with their care needs which otherwise might of gone unmet. For example staff left drinks on a table for people but for most people they were not able to help themselves and needed prompting to drink enough for their needs.

People were supervised as far as possible for their own safety. We observed call bells in easy reach of people and staff responding quickly to these. One resident said that they rarely had occasion to use their bell and that they had recently pressed the emergency one by mistake, "Within a matter of seconds there were 3 carers in my room." However we noted on the dementia unit staff were not always visible which meant that people were left unsupervised and we observed potential risk to people using the service.

At lunch time on the ground floor we found some people did not get the support they needed to promote their independence. For example one person ate food on their lap, dropping it down their front which went unnoticed by staff, another chased food around the plate as they were unable to use both hands. We asked them about the support they required to which they replied, "Not everyone gets the attention they deserve."

We spoke to staff and asked them were there always enough staff to meet people's needs. Staff told us generally there was a low turnover of staff and staff were familiar with people's needs. However one staff told us "We could do with an extra member of staff. We are always very busy and don't get time to sit with people often or meet their emotional needs. "We asked another staff member when they had time to sit with people and they said, "Sometimes after tea and in the evening."

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People felt safe and staff knew how to protect people as far as possible from avoidable harm and abuse. Three people told us that they felt safe in the home. One person said, "I feel safe. I'm quite happy here. The staff all treat me well." Visitors we spoke with had no worries about the safety of their relatives. One relative said that they felt their relative was "completely safe," that the staff are well trained" and they had seen them "being so gentle, assisting and reassuring people who were confused or distressed.'"

Staff told us they had received training and knew what actions to take to protect people they thought might be at risk of harm or abuse. All staff were familiar with policies and knew who they should report concerns to both internally and externally. Staff said they were confident any concerns would be acted upon. We saw information about protecting people from abuse was readily available for staff and visitors to access so they would know what actions to take.

We had received a number of notifications from this service where people potentially were at risk from other residents. The staff had acted appropriately to protect people, respond to risk and put in appropriate support to ensure all residents safely.

Assessments identified risk and care plans told us how the risk was being managed in relation to falls, maintaining skin integrity, weight loss and dehydration. People's care

Requires Improvement

Is the service safe?

plans told us when there had been a change in a person's need which could affect their well- being. This was linked to a risk assessment and then kept under review. For example if a person had fallen we were able to see what actions the home had taken to promote the persons safety. Where a person had developed an infection this was recorded as it could have implications for that persons care such as reduced appetite or increased risk of falls.

Staff who administered medicines received comprehensive training in medicines management, regardless of their previous experience. Their practices were assessed to ensure they were competent and any mistakes in medicine administration resulted in additional training and assessment of competence.

Staff we spoke with had an understanding of people's needs in relation to their prescribed medicines. We identified a minor concern with some people's medicines which needed to be given at a certain time to be effective. Records did not indicate if this happened in practice. We also found that at times staff were not using the right code to indicate when medicines were omitted. This was brought to the manager's attention so they could deal with immediately.

We observed the medicines round on two separate floors and saw that the staff member gave medicines appropriately and safely to people.

People we spoke with told us that they were happy with the way that staff gave them their medicines. They confirmed that their pain was well controlled. The home used a recognised pain monitoring scale to assess people's level of pain. This was for people with dementia or those who had limited verbal communication. This helped staff accurately measure and control people's pain levels. None of the people living in the home were managing their own medicines but assessments were completed to see if people were able to and people were encouraged to where able.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to have enough to eat and drink for their needs. We saw nutritional assessments were in place and there were records telling us what actions the home had taken to reduce the risks to people who were not eating, or drinking enough. However we found ineffective monitoring of this so could not see if the risk was managed effectively. Some fluid charts showed very low recorded fluid intake and no evidence that this had been reviewed when the recommended fluid intake of 1.5 Litres had not been reached.

During our inspection a number of people had infections and one relative told us their family member kept getting reoccurring water infections. We looked at one person's records and saw that they had developed a pressure sore and was described as having increased confusion. We saw an entry which described their urine as very dark brown. However there was no analysis of this. Their fluid chart showed varying amounts of fluid intake but the lowest recorded amount was 75mls, the highest 595mls. Their care plan said they needed 1.5 litres. Their appetite was poor and they had started to lose weight. They had being referred to the dietician but they were not given any nutritious drinks or snacks to supplement their diet and encourage their appetite.

We spoke with staff about this and they were unable to offer an explanation. They said fluid totals were added up by night staff at the end of the shift. However we identified differential recording practices within the home. Night staff kept manual records and day staff kept computerised records which meant record keeping was unreliable and there was poor evaluation of some aspects of care. When we fed this back to the manager and area manager we were told that staff should all be using the computerised records. Staff we spoke with said it was sometimes difficult to record the care delivered effectively because they were busy throughout the morning and then it was difficult to remember the care they had given.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Most people spoken with told us the food was good and there was sufficient choice for people. One person said, "Good food, but if you don't like the choice then they will cook something you do fancy, I said I fancied bacon and eggs the other day instead and I got it." Other people told us they did not always like the food, One person said; "We have a lot of stews."

We observed that people in their rooms had a drink within reach and people told us that they received regular drinks and snacks. We saw water jugs in rooms and lounges, plus biscuits and fruit. There was also a tea/coffee maker in the reception area where anyone could help themselves. The chef told us and people confirmed that when someone was at risk of unnecessary weight loss food was fortified to give it extra calories and supplements were used to promote weight gain.

We observed lunch being served on each of the three floors. Staff gave people who needed assistance with their meal appropriate support. However we noted some people who were more independent would have benefitted with a bit of support to help them maintain their independence and dignity. Food was served to people efficiently and people did not have to wait which meant their meal was served hot. People were offered a choice of menu, and offered a second portion when they finished their meal. People were given choices about their food but we did not see staff showing the different food options to people who might not be able to verbalise their choice. People were also all offered a choice of cold drinks.

Staff were appropriately supported to enable them to deliver care effectively to people. People told us that the staff were good. One told us, "They seem well trained". Staff spoken with told us they received sufficient training for their job role and said their training was up to date. Staff training was recorded on a matrix and monitored by the manager to ensure it did not lapse. Staff told us they received training to help them meet people's specific needs such as dementia care training, diabetic, catheter care and end of life care. Staff said some of the training was completed through computer based training, but other training was face to face and competency based assessments were completed to ensure staff understood the training. A nurse development manager provided training and consultancy to the home and met with staff on a monthly basis to coach them.

Staff said there were good induction and probationary processes in place for new staff. One staff member said "The company training is amazing. I've had lots of training since I started." Staff confirmed they were supported when

Requires Improvement

Is the service effective?

first on shift by more experienced staff until they felt confident with their job role and the needs of people. They completed all the necessary training and skills based induction within the first three months. Staff said the received regular supervision of their practice. One staff told us when describing senior staff. “They are really approachable and knowledgeable.”

The home had effective recruitment processes and staff were only employed after a rigorous process to ensure staff were suitable to work with older people and had the right credentials. However we found some staff did not have the skills to communicate effectively so that they can carry out their roles and responsibilities. Our specific concerns were shared with the manager to address.

Consent to care and treatment was obtained from people in line with legislation. The home supported people to make appropriate decisions about their care and welfare. People’s capacity was assessed to judge where people could make decisions about their care, and, or welfare. Where people were unable to consent to care or make specific decisions this was recorded and we saw how the home acted in people’s best interest. This was done in discussion with family members and other relevant health care professionals We have been given notifications from this home where one person had potentially infringed the rights of another. This was assessed and support given to both parties to ensure their health, welfare and rights were upheld.

The home had policies in place to support staff in understanding the MCA and DoLS safeguards and the manager acted appropriately to ensure people’s rights were upheld.

People were supported to maintain good health and had access to healthcare services. Staff were familiar with people’s needs and said they recognised when people were unwell, even when people were unable to tell them. We observed the community matron visiting people who were poorly. One person said they were feeling unwell and were immediately seen by the matron who told us they had already been seen by the doctor but they were just checking the person to make sure they were getting better. When people were visited by health care professionals this was recorded in people’s care plans and care plans were updated to reflect the changes to people’s needs. This was handed over to staff during staff handover so they could continue to meet people’s changed needs.

People told us that they saw their GP when they needed to. The district nurses and community matron provided additional support to people living on the two residential floors. People said that a member of staff escorted them if they needed to go to a hospital appointment. This made it easier for them to cope with the travel and the hospital environment. This was at odds with what one relative told us. People told us they had regular health care checks including: chiropody treatment and annual eye checks. This was recorded in people’s care plans.

Good

Is the service caring?

Our findings

We observed positive caring relationships between staff and people using the service. This relationship was extended to families. One person told us 'I am very happy, and looked after very well. All the staff are very pleasant, kind and good and if you ask for something, they will oblige you, I can't fault it'.

One relative asked to speak with us to tell us about the care of their family member. They told us they were "amazed at the gentleness of the care and the compassion across the board, all the way from the cleaners to the manager. This place cannot be bettered, the manager is top notch' and 'their patience is amazing, these guys deserve recognition."

Relatives were seen popping in throughout the day and care staff were acknowledging them and chatting to them. Everyone seemed to be very at ease. There were areas in the home where they could meet their family member in private and make themselves a hot drink.

Relatives told us their family members were encouraged to take an active part in the local community and people either went out or members of the community came in. Such as volunteers, singers and school children. Trips into town, the garden centres and pubs for lunch had been arranged to keep people connected with their past and their community.

We observed the care being provided to people and saw that staff were familiar and knowledgeable about people's needs. Staff remained calm and was able to diffuse situations which arouse between individuals. For example one person entered the lounge. They were upset and were shouting loudly. Another person started to shout back at them. Staff reassured both people and diverted their attention on to something else which had the effect of calming both of them down.

One relative told us that their family member moved here after they were no longer able to care for them at home. They said each time they use to visit their family member was distressed and wanted to come home but had now settled. They said they have settled because they have a routine, and saw familiar faces each day. They said the staff who provided care were very kind and patient. This was something they greatly appreciated as they said due to their family member's dementia their behaviour could be very difficult. The relative said they were always welcome at the home and could continue to support their family member and received support themselves from staff.

The service supported people to express their views and make decisions about their care, treatment and support. One person told us "staff often pop in and have time to chat. They have taken the time to get to know me well." They told us they had been involved in writing their care plan when they moved in and said they told staff what they could do for themselves and what they needed help with. Care plans showed us people's needs had been reviewed and people had consented to different aspects of their care. In some instances with the involvement and support of family members or other health care professionals.

Some people told us they were regularly involved in resident/relative meetings and were able to make suggestions about the running of the home. People also told us about the choice of activities and said if they chose not to join in this was respected but they were always told about what was going on.

Relatives told us they were kept informed of their relatives' care and changes in need which they said staff responded to quickly.

People's privacy, dignity and independence was respected and promoted**.** One person told us "I feel completely safe and staff assist me with anything I need. They help me and facilitate my independence." They said "I like to do as much as possible for myself and staff support me with this. " Another said the staff are excellent' 'they are very sociable and have always got time for me' 'they understand what my limits are and will give help, but only when I request it, I want to be as independent as I can possibly be.'

We noted that throughout the home the atmosphere was relaxed, some people were in their room and the manager said this was their choice with many people choosing to have breakfast in their room. We saw that most people ate lunch in the main dining room and staff told us that people were seated according to their choosing and according to their needs. Music was on throughout the home and televisions were on but did not dominate the home which meant people could chose to watch television in a room where it was on or sit quietly in another room where it was not.

Good

Is the service caring?

There were signs on people's door to let others know that staff were assisting people with personal care so they should not be disturbed to protect people's dignity. It also enabled us to know where staff were.

We observed staff assisting someone to use a hoist. They did so sensitively and explained what they were doing. The relative said they could get distressed by the hoist but did not on this occasion because staff skilfully managed the situation and upheld the person's dignity.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person told us, "I can do what I like, when I like. I prefer to stay in bed but if I want to get up they help me."

People had a comprehensive assessment of their needs before admission. The home tried to involve the family and asked them to complete a pre-admission care diary. This gave staff information about people's preferences and routines. Life histories were all collated where possible before admission or soon after. This also helped staff to get to know people better and respond appropriately to their needs.

We looked at people's care plans which were mostly stored on a computerised system and all staff had their own log in details. There was the opportunity to filter what information you needed, so you could see at a glance when a person's needs had last been reviewed, what risk assessments were in place and people's current needs. Care plans were in place for all areas of daily living and there was some personalised details such as what people's favourite colour was, where they went to school and their children's names. This kind of information enabled staff to provide personalised care.

People and their relatives were involved in their plan of care where able and records were kept to show when staff have contacted family members or other health and, or social care professionals with brief details of what was discussed or if any follow up was required.

Care plans and health action plans gave detailed information about how a person's needs should be met. There was evidence that they were regularly reviewed to identify any changes in the person's needs.

Most staff we observed have good interpersonal skills and communicated with residents well. However we noted several staff did not demonstrate the same empathy. Their manner was at times brusque, hurried and somewhat impatient. For example at lunch time we saw staff did not sit with people to encourage them to eat and drink and the atmosphere in the dining room was quiet with little interaction. We saw one person being assisted with their meal, one staff member gave them their main meal and chatted throughout, and another member of staff gave them their pudding and did not say a word to them until they had finished their pudding. They also assisted the person very quickly which might not have been a pace that suited the person who was unable to tell us. This was fed back to the manager and area manager who was keen to do some work around this to support staff with their interpersonal skills and provide additional training when necessary.

Most people were happy with the amount and range of activities that were on offer. One person told us "I get involved in the activities I want to do, and the activities co-ordinator comes round to visit and tells me what is coming up, but most of the time, I just prefer to stay in my room and read." Another said, "The programme of activities is very good, I like the entertainers." People particularly mentioned the entertainer/singers and outside visits to garden centres and pubs, and quizzes and said that they were at liberty to participate or not, as they wished.

Forthcoming events and activities were advertised throughout the home and facilitated by two staff and a number of volunteers. The activity programme was varied and took into account people's individual interests and hobbies. For example on the dementia care unit the activities were largely

'Music based – dancing, singing and using instruments such as tambourines and pompoms. 'Bible Stories coffee mornings' had just been introduced and were working well. On the nursing unit where some people were very poorly there was a greater emphasis on gentle exercise to music, singing, quizzes, one to one chats and hand massage.

The service routinely listened to complaints and learnt from people's experiences. One person told us they felt confident that they could speak to the manager or any of the senior staff, or raise anything at residents meetings and that it would be listed to and addressed. This was also the view of other people and visitors we spoke with. There was a notice in reception giving a free-phone number to call regarding 'Compliments and Complaints.' This meant people were aware of how to complain and felt able to raise concerns.

We noted that visitors were greeted by the receptionist as they arrived. They were immediately able to answer any concerns visitors had. The manager was also available to speak with should people wish. Regular resident/relative meetings gave people the opportunity to raise concerns. We saw that a number of concerns had been raised with

Good

Is the service responsive?

regards to people's laundry and the quality and variety of food. One person told us about a poor experience they had regarding their clothing but said this had been resolved to their satisfaction. Another relative told us issues around the poor quality of food have continued despite this being brought up several times. We saw minutes of meetings which showed what actions were being taken to address people's concerns.

Good

Is the service well-led?

Our findings

The manager promoted a positive culture that was person-centred. The manager was well established at the home and had many years' experience. They were well supported by a senior team of staff and told us they felt well supported by the organisation and their manager.

One person told us, "I think the home is well managed." Staff told us that they had excellent support from the manager and senior staff.

Throughout the home there was information about the service and evidence that family members were kept informed about anything affecting their family member. The home produced a newsletter to keep people informed about what was happening in the home. The home had developed good links with the community such as an established network of volunteers and community groups such as the local college and local schools. This meant the service was inclusive.

The home also provided coffee morning and lunch facilities for older people in the community. The manager commented that sometimes people became permanent residents after spending some time at the home initially through the day or after a period of respite care This meant they were familiar with the home and the staff were familiar with their needs.

There were systems in place to ask people for their views about the home, through monthly resident/relatives meetings and a more formal review of the service. This enabled the manager to identify where they were performing well or if there were any concerns about the service. Most people who said they had raised concerns were happy with the outcome and said their concerns had been addressed.

The manager told us they had a low staff turn- over with no use of agency staff. She told us this helped them maintain high standards of care through investment in their staff. She said staff were well supported through training and supervision which helped with their professional development. Staff received training and mentoring through a training consortium. Staff met regularly to discuss the training provided and how they would implement it in practice and utilise their skills. Some staff were doing accredited awards to help enhance their skills such as End of life gold standards award. Some staff had recognised qualifications in dementia care to help them support people living with dementia and support other staff in providing high quality dementia care. When we spoke with staff we found them to have a good understanding of supporting people with dementia and how to minimise people's distress.

The service was continuously striving to improve its performance and reduce risks to people using the service. They did this by a schedule of clinical audits and provider visits which were used to identify how the home was managed and where, if any the shortfalls were so these could be rectified. In addition to an electronic care plan system the home had an intranet compliance system in which they recorded all complaints, compliments, and residents risk status: including falls, nutritional status and skin integrity. This meant the manager and the senior managers of the company could review at a glance what the current risk status of the residents were. This helped them to monitor actions being taken to ensure it was appropriate to the level of risk identified and to monitor themes and trends to help alleviate risk factors. This system also recorded maintenance needed so that it could be addressed in a timely manner.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services and others were not protected against the risks associated with malnutrition or dehydration because the home did not maintain adequate records or effectively evaluate the care provided in relation to people's nutrition and hydration needs thus putting people at risk. Regulation 9.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not always enough staff to meet people's needs in respect to their health and welfare. Regulation 13.