Masterpalm Properties Limited

Stoneleigh House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was conducted by one inspector, and took place on 26 and 27 October 2016. Our visit on the 26 October was unannounced. We last inspected the home in September 2013. At that inspection we found the service was meeting all the regulations that we reviewed.

The service is registered to provide accommodation for persons who require nursing or personal care, and can accommodate up to 31 people. At the time of our inspection there were 22 people living at Stoneleigh House.

Stoneleigh House is a large stone built property which has been converted and extended. It is located in the Springhead area of Oldham, approximately three miles from Oldham town centre. Most of the bedrooms were single, but there were two shared rooms. However, at the time of our inspection one of these rooms was unoccupied, and just one person occupied the second. All bedrooms had sinks and ensuite toilets.

The home had a manager registered with the Care Quality Commission (CQC) who was present when we inspected. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the lack of security on entering the building, as we were able to gain entry without the knowledge of the staff, and walk throughout the whole of the building. You can see what action we asked the provider to take at the back of this report.

The home was well maintained. Bedrooms, dining rooms, lounges, bathrooms and toilets were clean and warm. Communal areas and corridors were kept free of any clutter to minimise the risk of accidents.

People who used the service told us they felt safe. When we spoke to staff, they were able to tell us how they ensured that people were protected from harm. We saw that recruitment procedures were sufficiently robust to help ensure that people were protected from the risk of unsuitable staff being recruited.

People were supported by a stable staff team who were knowledgeable and well trained. They had worked together for a number of years and knew the people who used the service well. We saw that there were enough staff and people told us that the staffing ratio reflected the needs of the residents. The staff we spoke with had a good understanding of people's individual needs and the support they required.

Where risk was identified, plans were put into place to minimise harm. Plans were detailed and subject to regular review. We saw that actions taken had reduced or eliminated risk, but this was not always reflected in care plans.

There were appropriate systems in place for the safe administration of people's medicines.

People who used the service told us the food was excellent. Attention was paid to dietary requirements and we saw the food looked and smelled appetising.

We saw that arrangements were in place to assess whether people were able to consent to care and treatment, and people were offered choices about how their care was delivered.

Where health needs were identified, the staff at Stoneleigh liaised with appropriate health personnel, such as doctors, district nurses and dieticians to ensure that health needs were not neglected.

People were treated in a caring and compassionate manner, and were complimentary about the care they received at Stoneleigh House. One person told us, "The staff really know how to look after us. All of them are kind and caring, and always smiling", however, they told us that there was often little for them to do.

Systems were in place to ensure that people at the end of life received appropriate care in accordance with their wishes, and were supported with the relevant healthcare as needed.
Care plans documented people's interests and what they enjoyed doing. Staff were encouraged to help people to maintain their interests. However, people who used the service told us that there was not a lot for them to do.

The service had a complaints policy, but there were few complaints. One person told us, "I sometimes have an issue but I will talk to the staff and they will put it right. Things have never got to the point where I have needed to complain".

People told us the manager was approachable and would listen and respond to any issues raised. The home regularly sought feedback, and took action to improve the quality of the service.

Prior to our visit, we contacted the local authority safeguarding and commissioning teams, and no concerns were raised by them about the care and support people received at Stoneleigh House.

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

Is the service safe?

The home was not always safe.

Security of the building was poor, and we were able to enter unannounced.

People told us they felt safe and arrangements were in place to safeguard people from harm.

There were systems in place for the safe management of medicines.

The home was well maintained.

Is the service effective?

Good

The service was responsive.

People told us the care staff responded promptly to their needs.

The service had systems in place for receiving, handling and responding appropriately to complaints,

Care records contained detailed information about people and how they liked their care to be delivered.

People told us there was not always enough for them to do

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well.

Staff treated people in a caring and compassionate manner Staff agreed that this was important and spoke affectionately about the people they supported.

People's privacy and dignity was respected.

People were supported to receive good care at the end of their life.

Is the service responsive?

Good

The service was responsive.

People told us the care staff responded promptly to their needs.

The service had systems in place for receiving, handling and responding appropriately to complaints,

Care records contained detailed information about people and how they liked their care to be delivered.

People told us there was not always enough for them to do.

Is the service well-led?

Requires Improvement

The service was not always well led.

Managers and staff were not always aware of who was in the building, and visitors were not asked for identification.

The service had a manager registered with the Care Quality Commission (CQC) who was held in high regard by staff and residents.

Systems were in place to assess and monitor the quality of service provision, and the service had developed good systems to analyse incidents and accidents.

The registered manager understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Stoneleigh House

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 26 and 27 October and was unannounced. The inspection team consisted of one adult social care inspector. Before this inspection, we reviewed the information we had about the home including the previous inspection report and notifications that we had received from the service. We also contacted the local authority safeguarding and quality assurance team to obtain their views about the service.

We asked the provider to complete a Provider Information Return (PIR), prior to this inspection. 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 was returned to us in a timely manner.

During this inspection, we spoke with four people who used the service, and relatives of three people. We had general conversations with other people who used the service and their visitors. We spoke with the registered manager, deputy manager, four care staff and the chef.

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

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

We looked at the care records for four people, four medicine administration records and three staff personnel files. □

Requires Improvement

Is the service safe?

Our findings

When we arrived at the care home the front door was open, and we were able to freely enter the building. We were not challenged as we walked throughout the whole of the property. We spoke with some people who used the service and encountered a domestic assistant on the top floor, but nobody asked who we were or checked our identity until we found the deputy manager. This meant that people who used the service were not protected against unwarranted intrusion; their personal belongings and records were not secure and they would be able to leave the home without the knowledge of staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: the registered person must ensure that premises are safe.

We saw that the entrance was normally secured with a locked door and key code entry system, but the door was left ajar by the previous visitors. When we informed the registered manager of this, she immediately put up a sign by the front door reminding all visitors to ensure that the door was firmly closed on exiting the building.
People told us that Stoneleigh House was a safe place. One person who used the service said, "Oh yes, they make sure I am safe. There is bound to be the odd quirk now and again but the girls are good and look out for me", and a visiting relative we spoke with told us, "It's very safe. They keep a close eye on [my relative] and notice if there is anything not right. If there is, they ring me right away. The staff know [my relative] really well. I'm very happy, definitely the right place for her".

Training records showed that staff had received training in safeguarding adults from harm, and when we spoke with care staff they demonstrated a good understanding of the triggers to abuse and signs to watch out for which might indicate abuse or harm. One member of staff was able to describe the process they would follow if they suspected abuse. They discussed the safeguarding and whistleblowing procedures showing knowledge of the systems and processes to prevent harm. Although the care staff we spoke with had never had to use these procedures, they told us they would follow up concerns until they were sure the issue had been dealt with. They recognised that some people who were living with dementia were often unaware of risk. One staff member told us that the people who used the service did not always get on with one another, so staff needed to be vigilant and watchful to prevent any escalation of events. They explained the steps they would take to calm people down or gently encourage people away from potential flashpoints. The registered manager was aware of her duty to report relevant incidents to the local authority. We checked the monthly incident log, which showed that she was reporting all issues appropriately.
Stoneleigh House had a homely atmosphere. One visitor told us, "It is a care home, but it is their home and this is respected". People who used the service had unrestricted access to all communal areas in the home; there were no restrictions on visits and people could choose what they wanted to wear and what time they wanted to get up or go to bed.

We looked around all areas of the home, which looked onto a well-maintained garden, with a smaller paved area accessible from the dining room through patio doors. Bedrooms, dining rooms, lounges, bathrooms and toilets were clean and warm. Communal areas and corridors were kept free of any clutter to minimise

the risk of accidents, and covers were in place on all radiators to prevent risk of burns.
We saw the doors to rooms where dangerous or hazardous equipment was stored had warning signs and 'keep locked notices' displayed on them. When we tried these doors, most were locked, but we saw a linen cupboard on the first floor had been left unlocked, despite the sign on the door. When we informed the registered manager about this, she ensured that the door was immediately locked.

The laundry was situated in the cellar, accessible using a key code to prevent anyone who used the service from falling down the steps. The laundry was well equipped with hand washing facilities, two washing machines and two tumble driers, which meant if one broke down staff could continue to complete the laundry using the second machine. We saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

Communal toilets and bathrooms were well stocked with soap, desanitizer, and paper towels. Disposable aprons and gloves were available. Pedal bins with appropriate colour coded bin liners further reduced the risk of cross contamination.

We checked the kitchen and saw that it was clean and that the fridge temperatures were monitored regularly and food stored safely to prevent any risks of cross contamination or food wastage.

We looked at a number of operational and environmental risk assessments that were in place in the service including moving and handling, lone working, control of substances hazardous to Health (CoSHH) including uses and storage of detergents and cleaning materials, fire safety and risks to or from visitors. These showed consideration to how people might be harmed, and actions in place to minimise the risk. This would help to ensure that people who used the service, staff members and visitors were protected against any risks within the service.

The service employed a maintenance officer, and staff compiled a list of any faults or broken equipment that the maintenance office would sign off and date as work was completed. When we inspected there were a small number of outstanding jobs to be completed, such as replacing a carpet, replacing bulbs and fixing a broken drawer.
We saw there was regular maintenance by external professionals. This meant the electrical installation and gas equipment was safe. We also saw documentation for the lift, hoist and sling checks, the control of Legionella and portable appliance tests (PAT). This meant equipment was safe for staff and people who used the service.
The service had a business continuity plan to inform staff of how the home could function with a loss of facilities such as gas, electricity or bad weather. Each person who used the service had a personal emergency evacuation plan (PEEP) which informed any emergency services what support each person needed to leave the building safely. The fire alarm and call bell system was also checked monthly to ensure they were working correctly. There was a record of fire drills with staff being taught evacuation of the premises and the fire break points were checked on rotation to ensure they were working.

Accidents and incidents were recorded and the registered manager audited them to see if they could minimise any risks identified. This helped protect the health and welfare of people who used the service. In addition, the registered manager had set up a 'Corrective and Preventative Action' file in which she recorded all out of the ordinary events, such as infections, accidents, complaints and safeguarding concerns. This allowed the service to cross-reference any incidents and identify root causes, assisting them to implement plans to minimise the risk of future occurrences.
We saw that there were appropriate systems to prevent and control infection. There was an infection control policy in place to guide staff in the prevention of cross infection, rules to prevent the spread of infection,

blood borne viruses, outbreak control measures, clinical waste, skin infections and recording. Staff we spoke to understood the importance of infection control measures, and we saw they used personal protective equipment including tabards, disposable gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

We looked at four case records and saw people had individualised risk assessments. Each assessment identified the risk to people, including such risks as falls, moving and handling, pressure relief and nutrition, with clear plans in place to show how to minimise the risk. Risk assessment was on-going and where possible involved the person. We saw that where risk had been identified a corresponding and detailed care plan was put into place to help reduce or eliminate the identified risks. Risk assessments were reviewed on a month-by-month basis. We saw that appropriate intervention had reduced risk, for example in one care record we noticed the risk of developing pressure ulcers had reduced following the implementation of protective measures to maintain good skin integrity.

The service recognised risks to people's health and well-being, but aimed to maximise the person's autonomy. For example in one moving and handling risk assessment we saw instruction for care staff to "encourage [person] to raise herself on standing and to manage a few steps each time she is assisted with transfers to build her confidence, strength and mobility to enable her to return home".

We saw that staff understood the risk to people and followed written risk reduction actions in the care plans. There were systems in place for staff who cared for people on a daily basis to input their observations on people's safety and welfare.

People who used the service told us that they believed there were enough staff to meet their needs. One person told us, "Yes, there are enough, there is always someone nearby". When we asked the care staff, they told us, "sometimes we are a bit rushed, but generally it's OK". Another care worker told us they felt that there were enough staff on duty at any time, but administrative tasks and record keeping could sometimes take them away from being able to spend time with the people who used the service. Although they completed these recording tasks in communal areas, they felt that they were unable to have any meaningful conversation or interaction whilst focussing on note writing.

The registered manager told us that they used a dependency tool to determine the number of staff required, but if they had any people in the service who required extra assistance the providers were amenable to providing the required support. There were generally four care staff on each shift with two waking night staff. In addition, the registered manager and deputy manager were available and operated a 24 hour on call system. We looked at the staff roster, which was planned in advance. If ther were any gaps due to leave entitlements or sickness, extra shifts would be offered out to regular staff as overtime. We were told that any sickness was generally covered by regular staff. If required staff from other homes owned by the service would be asked to provide support, but one member of staff told us this was very rarely needed, as they were willing to work extra to support other staff and the people who used the service.

An established staff team supported people who lived at Stoneleigh House, and there was low staff turnover. This meant that people were cared for by staff who knew them well.

We looked at the recruitment procedures, which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Stoneleigh House. We looked at four staff files. These contained proof of identity, an application form that documented a full employment history and accounted for any gaps in employment, interview notes, a job description, and two references. Checks

were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and copies were kept on the personnel files. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Stoneleigh House.

When we reviewed staff files, we saw an instance where issues of poor conduct had been raised with the registered manager. Appropriate disciplinary processes had been followed, including verbal warnings, and proportionate action had been taken to reduce the risk to people using the service, including close monitoring and supervision.

We looked at the system in place for the safe storage and management of medicines. Medicines were ordered by the deputy manager and delivered on a monthly basis by the pharmacy using a monitored dosage system with blister packs. This minimises the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Prescriptions were checked against delivery, signed for and countersigned to ensure that the appropriate medicines were delivered. Unused medicines and tablets were noted and stored in a returns box for returning to the pharmacy.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature, they can lose their potency and become ineffective.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments), such as morphine or pethidine. These medicines are called controlled medicines or controlled drugs. We saw that controlled drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form, which records the details of any medicines prescribed, when they are taken and if they are refused. All medicines received were recorded on the MAR which also included details of the medication and dose required; details of the person's GP, condition, and any known allergies.

Medicines were administered by senior care staff who had received specific training on handling medicines, completed a competency questionnaire and demonstrated their ability to perform the task. We spoke with one senior carer who informed us that they had completed regular medication training and confirmed that they were happy with the training received.

Good

Is the service effective?

Our findings

People told us they were supported to have their needs met by competent and well trained staff. One person said, "They deal with some very different and difficult people here, with different needs but they all seem to know what to do." A visitor felt that the care staff were well trained and able to apply their knowledge to provide good care for their relative. They said, "I can come anytime, talk to anyone and they all know about my mum. The same staff, all familiar faces. She's been looked after brilliantly, staff are so knowledgeable but also caring and cheerful". This person told us that they had observed staff working with the other people who used the service, and explained that they felt staff were versatile, and "able to anticipate and cope well with very different people who have difficult needs".

We saw from records and discussions with care staff that when beginning work at Stoneleigh House all staff received a full induction and care staff spent up to two weeks shadowing a more experienced member of staff until both they and their supervisor felt that they were ready to be signed as competent.

When we spoke with care staff they told us that the service was committed to providing good training. All staff had completed a self-assessment tool to determine if they had reached the standard required for the care certificate. This is a professional qualification, which aims to equip health and social care staff with the knowledge, and skills which they need to provide safe and compassionate care. Six members of staff had enrolled on the full course. Other staff had an equivalent qualification, such as NVQ 2 in Care, or higher.

The service set clear expectations for the staff and provided on-going training to ensure that staff had the skills to carry out their role. From the training matrix (record), which maps out the training staff have completed, we saw that all care staff had completed courses in such areas as safeguarding adults, first aid, food hygiene, dementia awareness and moving and handling. Additional training in medication and safe administration of medicine was provided for senior care workers with refresher training every two years. Other specific training was also available; one care worker we spoke with informed us that they had attended training around dysphagia, (problems with swallowing) and found the information beneficial in working with people who used the service who had difficulty with eating and speaking. Three members of staff were completing a training course on Care for the Dying, which followed the six step principles of end of life care.

People told us, and we saw in staff files that they received supervision every six months. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at four staff supervision records, which showed that meetings were productive and staff used the opportunity to discuss issues of concern. Notes reflected issues raised and action points to ensure that follow up actions were taken.

We saw staff communicated well with each other. Tasks were delegated at a handover meeting at the start of each shift, and care staff told us that they were comfortable with the tasks they were given. One care worker told us, "we all work as a team and we know how to work with each other, so we can split the tasks equally." To assist day-to-day communication the staff used a communication book and signed off any

outstanding actions. This also provided instruction to staff coming onto a shift which ensured continuity of care, and that tasks were not overlooked.

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.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Stoneleigh House was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us and we saw information to show that applications to deprive people of their liberty had been authorised by the supervisory body (local authority), or were awaiting authorisation. The provider had informed CQC where authorisations had been granted as is required. Capacity assessments had been completed to determine why people needed a DoLS authorisation. Where a DoLS had been requested or authorised the information was stored within the person's care records, and the registered manager kept a central list which showed the details of any DoLS applications, authorisations and dates of expiry. This meant that they were aware of any DoLS which were in place and when the authorisation would lapse, and acted as a reminder to seek renewals where necessary.

The care staff we spoke with were able to demonstrate a good understanding of capacity and consent issues to help ensure that people's rights were protected, including pathways to reach best interest decisions. We saw that care staff asked for the person's consent before carrying out care and support tasks. We observed this in practice, for instance, we saw a care worker knock on someone's door before entering and asked if they required assistance to dress. At lunchtime, care workers asked people if they wanted help to eat their meals.

People and their representatives told us that they were offered choice in the delivery of their care and support. One person told us, "I am asked what I want to wear and I can please myself about most things. If I want a shower, I just need to ask and they'll give me one". We were told that there were no set times for people to get up or go to bed. A care worker told us that after supper people started to retire, and would ask for assistance when they were ready.

People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest. Where this was the case, information about contacting the advocate was clearly marked in care records to ensure they were consulted before any decisions were made.

People told us that they enjoyed the food provided at Stoneleigh House. One person who used the service said, "The food is good. We don't get a lot, but people like us don't need very much, so it's not over facing. We can help ourselves to biscuits. [The chef] is a marvellous baker and he makes beautiful cakes". Talking about the chef another person said, "The man is a genius. Food here is fantastic!"

Meals were freshly prepared and well presented with colourful vegetables, such as carrots and green beans, which helped to stimulate appetite. There was attention paid to nutritional content and meals were balanced and nutritious. For the main meal, which was served at lunchtime, a choice of two main courses

was offered. When we observed lunch, there was a choice of cottage pie or chilli, and second helpings were available. A choice of deserts was offered, and most people chose apple pie and custard. The chef informed us that he worked on a four-week menu, but would sometimes amend this to consider seasonal or special occasions, such as Bonfire Night, or Burns Night.

Specific dietary requirements such as sugar free or soft foods were available as required. Staff were aware of people's dietary needs and clear instruction was given in care plans, for example, "Pureed diet, little and often. Please ensure [Person] sits upright where possible when taking food and drink". Where people had been identified as being at risk of malnutrition or required specific diets, diet recommendations and foods to avoid were recorded and passed to the chef. Food and fluid intake was monitored and recorded.

There were systems in place to ensure people's health and well-being were monitored and reviewed. We saw staff documented any changes to people's health conditions and contacted the relevant professionals, for example, Speech and language Therapists (SaLT) or Continence nurses for advice. These were easily identified within their care plans. People were supported to attend annual health care reviews, and hospital appointments.

Good

Is the service caring?

Our findings

Everyone we spoke with was complimentary about the manager and staff at the care home. One person who used the service told us, "The staff really know how to look after us. All of them are kind and caring, and always smiling". A visiting relative remarked, "It's very good, I am impressed. All the staff including cleaners are really friendly. I've looked at posher homes, but this more in keeping with [my relative] because there's a sense of caring." When we reviewed the complaints and compliments log, we saw messages of thanks, such as "Thank you for your care and kindness, especially in those last days". Similarly, a response comment on a visitor survey stated, "I am very happy with [Person's] care. I think the staff are amazing!"

Relatives we spoke with told us that they felt comfortable visiting Stoneleigh House. There were no restrictions on visiting and people were made to feel welcome. Visitors we spoke to informed us, and we saw, that staff knew who they were, addressed them by name and were always welcoming.

People who used the service told us that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported. One staff member told us, "I enjoy the versatility, they are also different. They can be demanding but that's the beauty of the job, we get to know them and what makes them tick." Another reflected the caring culture of Stoneleigh House, and told us "This is a really caring home. Not everybody, but most staff will put out more than they have to. It's not always a nice job but we do it because we can and because we care".

We observed staff treat people in a caring and compassionate manner, with respect for their appearance and dignity. For example, when a person who used the service had a slight accident, a care worker noticed and kindly offered to take the person to the bathroom to "fix it for you." When we observed lunch, we saw that staff offered to help anyone struggling to eat their food, and allowed people the time to finish their meals without rushing to clear tables.

We saw staff would spend time talking to people and encouraging conversation amongst the people who used the service. We overheard a conversation, which started about the weather, and led onto a person telling an amusing anecdote about driving in the snow, and further conversation about driving mishaps.

We saw that staff addressed people by their preferred names, and spoke with them in an unassuming way, making eye contact and touch when appropriate. Staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. People told us they thought the staff listened to what they had to say. One person told us, "Nothing is too much trouble, they will go out of their way to help us".

People's care records made clear what people required support with to do and what they could do independently. People and their representatives were encouraged to discuss goals about what they would like to achieve, and individual needs were recognised and accommodated. Care plans were written in a person centred way, for example we saw one entry, which read, "[Person] is very hard of hearing but chooses not to wear hearing aid". The plan went on to inform staff how best to respond, with consideration for eye

level, pitch, and tone of voice when talking, and to repeat and reiterate to ensure effective communication. We observed that when staff were talking to this person they ensured that they followed this instruction to allow clear communication.

Care records also demonstrated a person centred response to changing need. Daily records showed that one person who used the service was retiring to their room earlier in the evening, so they arranged to set up a television in the bedroom so that she did not miss her favourite programmes.

The service had begun to introduce "This is me" biographies for each person who used the service to develop a life story. This helped to give a greater understanding of the person and recognise their individuality.

Staff treated people and their belongings with respect and understood their need for privacy. People were respected for who they were, and their personal preferences were taken in to account. In a questionnaire response one person commented, "No One interferes and I have plenty of company if I need it". A separate relative also commented, "[Relative] finds socialising difficult but does prefer her own company. Staff have taken this into consideration and respect her wishes". Information held about people, including all care records were securely stored I the manager's office when not in use, but staff had access and we saw that they regularly consulted care plans and assessment to ensure that they were providing appropriate care and support.

There was evidence that people's wishes for their end of life care had been considered. Information provided in case records included personal preferences, such as funeral plans where appropriate. Some staff were undergoing training on the Six Steps Care Pathway. This is a programme designed to provide quality care to people at the end of their lives. Staff told us that they benefitted from this training, and had taken steps to put the learning into practice, not only supporting people who are near the end of their life, but also their relations and friends. We spoke with the relative of one person, who told us they had been told their relative had been given just 48 hours to live last November. They told us, "she's still here nearly a year on. That is down to the fantastic care she has received here. We've had so much help. I can get upset, but the staff rally round for me as well as Mum."

All the staff we spoke with were keen to ensure that people had a dignified death. One care worker told us, "People should go out in the best way. We look at whatever they want, not to be lonely, to be comfortable and not in any pain. We will stay with residents if the family or others cannot be here, otherwise we give them privacy and a chance to grieve."

At the time of our inspection, there were three people who had been placed on the end of life care pathway. We were told by relatives that staff were supportive, and they would ensure that people remained well presented, care was taken of diet, and they were treated with patience and kindness. Care plans reflected the changing needs of people on the care pathway, for example, recognition of nutritional needs, or changes in medication. We saw evidence that where specialist equipment was required, the registered manager would advocate on behalf of people who used the service to obtain the appropriate supports to ensure their needs were met.

Good

Is the service responsive?

Our findings

People who used the service and their relatives told us that there was an appropriate and timely response to need at Stoneleigh House. One person told us, "I can't do a lot for myself so [The staff] help as much as they can." Relatives agreed that the service was responsive. One relative we spoke to said their family member was, "Settled and comfortable. She is well looked after, and safe. They spotted the early signs of illness so early treatment stopped her from getting worse".

People told us that they were supported in the way they had agreed and that the staff knew what they liked and disliked. One person told us, "If I have a moan they will correct it. They keep a good eye on me. I was having problems with my teeth so they arranged a dentist for me. They make sure I have enough to eat, they weigh me and keep an eye on my blood pressure. If there is anything the matter they call the nurses in."

Care plans were kept up to date and were reviewed on a monthly basis. There was evidence of annual reviews where relatives and other interested parties were invited consider any changes in need. People's care records clearly documented their needs and what support they required with day-to-day living tasks such as eating meals or with personal care, and meticulous care records detailed activities, mood, interactions and recorded daily checks on food intake, elimination, sleep patterns and personal hygiene. Weekly checks were made on weight, bathing and regular risk assessment Such as Waterlow pressure scores which measures risk of skin breakage, or Malnutrition Universal Screening Tool (MUST) which is a commonly used screening tool which helps identify adults who were at risk of malnutrition or obesity.

We saw where need was variable, the service operated a 'traffic light' care plan: this indicated to staff how best to respond to needs which were liable to change on a daily basis. Green would provide the regular response; amber would signify a response to an incident and red would provide a contingency plan in the event of an emergency. This allowed staff to respond in the most appropriate way to the presenting need and minimise any risks which might occur.

Care records for people documented their interests and what they enjoyed doing, and encouraged care staff to explore their activities and interests, for example "[Person] has a love of animals. Spend time with [Person] chatting about horses and pets".

Care records showed that plans were closely monitored, but records did not always match. For example, we saw in one case record that a person who used the service was assessed as high risk of developing pressure sores. Preventative measures included use of pressure relieving equipment and regular turning at night, and this helped to eliminate the risk. When we checked the turning records, we saw that staff had stopped turning the person in the previous week. We were told that this was because turns were no longer required, and case notes reflected discussion with the district nurse. The risk was outweighed by the disruption nightly turns would cause to the person's sleep. However, this change was not reflected in the care plan which had not been amended to signify the change in need. This recording error could lead to incorrect care being delivered. When we showed this to the registered manager she checked and changed the care plan to reflect the most recent need.

Staff worked effectively to improve the well-being and abilities of people who used the service. We spoke with one person who had been living at Stoneleigh House for nine months. They told us "When I came I was quite poorly, but they have helped me to convalesce and get better. I couldn't have done it without their assistance and kindness". When we spoke to the registered manager she recognised that this person had improved in health and the staff were encouraging them to become more independent, with a view to reassessing their need to remain in residential care

We saw that staff showed a good understanding of people, their likes and dislikes and interests. We saw one member of care staff talking with a person about his home town and the different characteristics of people from different towns. Throughout our visit we overheard a lot of conversation and banter between staff and the people who lived there.

We saw that when they had time, staff would interact with people who used the service, and try to find some stimulation, for example, staff would initiate conversation, and at one stage during our inspection we heard a member of staff organising an impromptu sing-along. However, this was sometimes short lived as they would be called upon to commit to other tasks. People told us that there was not always enough to do. When we reviewed the results of the resident and visitors questionnaire, the lack of organised activity was a common recurring theme. One person who used the service told us, "There's nothing to do here. There are no good books, so I just end up going to my room and doing crosswords and puzzles." The home employed an activities co-ordinator, and there was a list of weekly activities displayed on the notice board. However, on the day days we inspected, the activity plan was not being followed. When we asked people what they liked doing they were able to tell us that they enjoyed some of the activities, but some told us that they weren't interested in joining in the activities which were presented. When we raised this with the registered manager, she agreed to review the opportunities for people to remain active, and consider ways to provide a more person centred approach to leisure time pursuits.

Stoneleigh House had a complaints policy that was on display in the main entrance where it was easily accessible. People understood whom they could go to if they had a complaint or were unhappy about something. One person said, "I would speak to [the registered manager] if I was aggrieved." A relative commented, "I sometimes have an issue but I will talk to the staff and they will put it right. Things have never got to the point where I have needed to complain". We reviewed the complaints and compliments file and noticed that there had only been two official complaints logged in the past eighteen months. There was evidence of a full investigation, with a response detailing the actions taken to the complainant. One of these complaints had not been substantiated, whilst the second was found to have merit. There was an action plan to show that the service had learnt form the errors made and appropriate action had been taken. We contacted the local authority safeguarding and commissioning teams prior to our visit and no concerns were raised by them about the care and support people received.

We saw evidence of regular consultation with relatives of people who used the service and their views on service delivery were sought. People were invited to relatives meetings twice yearly and people were asked to complete a feedback questionnaire when they visited. The results of this questionnaire were used to improve the quality of the service. People told us that the home would stay in contact and inform them of any issues relating to the care of their relative. One visitor informed us that the registered manager or key worker would maintain contact. They told us staff were "always stay in touch and let us know. If we haven't been they'll give us a call to let us know how [our relative] is doing even if there is nothing much to report".

Requires Improvement

Is the service well-led?

Our findings

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. Stoneleigh House had a registered manager who had been registered for six years, and was present throughout the inspection.

Everyone we spoke with held the registered manager in high regard. One member of staff said, "She is a good manager, really supportive. I have never felt I couldn't go to her with an issue, either about work or about my personal circumstances. She can be firm though. At meetings, she will lay down the law, but offer praise when things are going well. She gives me confidence when I am not sure".

Stoneleigh House had a statement of purpose: "To provide our residents with the highest standards of care in a safe and clean environment with nourishing food, and a supportive role to them and their families". We saw that the service had developed a homely atmosphere, staff were friendly and relaxed, and people who used the service people were well dressed, and content. They told us the food was "splendid", and "excellent". We saw that people and their personal belongings were treated with respect, and that the staff team took time to get to know people's personal tastes and preferences. Key workers were assigned by matching personalities to help develop a person centred approach to care and to assist positive relationships and sharing of information.

There was an effective system in place to monitor the quality of the service. The registered manager completed quarterly audits and reported on care files; accidents; staffing and staff training; domestic services and equipment. In addition, she undertook regular assessments of the home and environment, and any action required was noted with actions followed up. She also undertook regular spot checks, for example, of maintenance records; activity programmes security systems and personal finance records. Monthly medicine audits ensured that any errors could be rectified, but there had been no errors reported in the past twelve months.

In addition we saw that the pharmacist who supplied medicines had completed a thorough audit on medicine storage, and administration earlier in the year, and the local authority commissioning team had found the service to be of a good standard when the visited in April 2016.

The service had appropriate policies and procedures, which were accessible to all staff who signed to say when they had been read. The registered manager reviewed all policies and procedures annually.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager kept a file of any out of the ordinary events, and recorded the concern, any activities prior to the event, who was present, and how they responded. This helped to identify the root cause of the event, and

allowed for close analysis of any emerging trends or patterns, and proactive intervention to improve the quality of care for individual people who used the service and for learning and improvement in general.

However, when we arrived at the service, we were able to enter, talk to people who used the service and walk through the home. Nobody asked us who we were or the reason for our visit. We were not asked for proof of identity. This meant that managers and staff were unaware of who was in the building, so the safety and security of the people who used the service and their belongings could not be assured.

Staff told us that they were involved in discussions about issues in service provision during team meetings. Minutes demonstrated that staff were encouraged to raise concerns and take responsibility where mistakes had been made. Staff told us they found team meetings useful, and felt supported to raise issues and suggest changes they felt needed to be made. We saw that the staff worked together as a team, and responsibilities were shared. We saw that there was a low turnover of staff. They told us they thought Masterpalm Properties, who owned and managed the service was a good company to work for, and that the service providers would assist with any reasonable requests for support.

The registered manager was aware of the importance of maintaining regular contact with people using the service and their families. Relatives meetings were advertised and relatives were invited to attend in order to feedback and share information about the home. The registered manager operated an open door policy and was available to privately discuss issues with relatives or people using the service.

People using the service and their representatives were given the opportunity to give feedback. Simple feedback forms were provided and comments sought on the care and treatment delivered. We looked at eight forms that were all positive, praising the work of staff and the safety, cleanliness and presentation of the people who lived at Stoneleigh House.

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 12 HSCA RA Regulations 2014 Safe care and treatment There were no security checks on entering the building and visitors were not challenged. Regulation 12 (1)(2)(d)