Care Quality Commission

Landona House Limited

Stapleton House

Inspection report

Stapleton House
Borough Road
Jarrow
NE32 5BL
Tel: 01914 300179
Website: www.landona.com

Date of inspection visit: 24 August 2015
Date of publication: 14/10/2015

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

Overall summary

This inspection took place on 24 August 2015 and was announced. This meant the provider knew we would be visiting. The service has not previously been inspected.

Stapleton House provides care for up to 45 people some of whom have nursing care needs. The service is based in a two-storey building, some of which was purpose built. At the time of the inspection there were 36 people using the service. 15 people were living with dementia.

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

People felt safe at the service. Risks to people's safety and health were appropriately assessed, managed and reviewed. Individual risk assessments were carried out and regularly reviewed. A robust recruitment and induction process was in place. Staffing levels allowed people to receive personalised and meaningful care.

Summary of findings

Staff were trained in safeguarding and whistleblowing and were able to demonstrate a working knowledge of both. The service had plans in place to ensure people's safety and a continuity of care in emergency situations.

Staff received appropriate training and felt confident in their ability to support people. Meaningful supervisions were carried out, which staff found useful in developing their skills and the service in general. People were offered a good selection of appealing and nutritious food, and those with particular dietary or nutritional needs were appropriately supported.

The service protected people's rights by ensuring they were not restricted unnecessarily unless it was in their best interests. The service worked collaboratively with the relevant authorities to ensure people's best interests were protected without compromising their rights, ensuring the appropriate procedures were followed.

People were supported with dignity and respect. The service had a homely and welcoming atmosphere. Staff were respectful, friendly and caring.

Care plans were detailed and personalised, which meant people received the care and support they wanted. Plans were regularly reviewed to ensure they reflected people's current wishes, and people and their relatives felt involved in this process.

The service provided a range of activities, and people were involved in developing these. The activities co-ordinator was aware of people's preferences and ensured that everyone was involved in activities if they wished to be.

The registered manager and the provider regularly assessed all aspects of the service to ensure that quality was maintained. Where complaints were received they were dealt with promptly.

Staff felt supported by management and described a positive, caring culture at the service.

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 safe.

Risks to people were appropriately assessed and managed.

People were supported by staff who had been appropriately recruited and inducted.

The service had up-to-date policies and procedures in place to safely manage medicines.

Good

Is the service effective?
The service was effective.

Staff received training to ensure that they could appropriately support people.

The service had clear procedures in place and worked collaboratively with others to ensure people's best interests were protected without compromising their rights.

People received support with food and nutrition and were able to maintain a balanced diet.

Good

Is the service caring?
The service was caring.

People were treated with dignity and respect, and the service had a welcoming and homely atmosphere. Staff knew the people they cared for and interacted with them in a meaningful way.

The service promoted the availability of advocacy services.

Good

Is the service responsive?
The service was responsive.

People's preferences were assessed and care was planned around them.

People had access to a range of activities that were tailored to their individual needs.

Good

Is the service well-led?
The service was well-led.

The registered manager and provider worked closely to carry out a range of quality audits and assessments and used the results to improve the service.

Staff felt involved and supported in running the service.

Good

Stapleton 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 24 August 2015 and was announced.

The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was nursing and care for the elderly.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch.

During the inspection we spoke to seven people who lived at the service and 11 relatives. We spoke with six members of staff, including the provider, the registered manager, senior care workers, carers and the activities co-ordinator. We looked at six people's care records and five people's medicine records. We reviewed three staff files, including records of the recruitment processes. We reviewed the supervision and training reports as well as records relating to the

management of the service. We completed observations around the service.

Good

Is the service safe?

Our findings

People felt safe at the service. One person told us, "It's lovely here, we're looked after." Relatives also told us that the service was safe and spoke highly of staff. One told us, "We have such confidence in the home to look after [relative], you hear such stories in the media, but here I have no worries at all." Another said, "We have no worries about safety here, it's so good."

Risks to people's safety and health were appropriately assessed, managed and reviewed. A 'Fire Risk Assessment' was carried out annually, and where risks were identified an action plan was created to record remedial action. We saw that appropriate checks were undertaken of water temperatures, fire systems, emergency lighting, hot surfaces, the nurse call system, window restrictors and sling and bed maintenance. Accident and Incidents were clearly recorded. An analysis of falls was completed on a monthly basis. The registered manager did a pictorial analysis comparing the times of day for each fall to look for trends.

Individual risk assessments were in place which meant risks had been identified and were being managed to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments. A personal care plan for each area was written using the results of the risk assessment, which described the actions staff were to take to reduce the possibility of harm. These had been regularly reviewed to ensure people's needs were met.

There was a safeguarding policy in place and staff received regular training. This covered abuse and neglect, recognising the signs and symptoms of abuse and neglect, prevention of abuse and neglect and appropriate incident reporting. Staff were able to identify the types of incident that might occur and felt confident to report it. One member of staff said, "If I suspected [abuse] I'd go straight to the manager and I'm confident the manager would do something about it." The service publically displayed information on safeguarding, demonstrating that it was everybody's responsibility to ensure people were safe. We saw the information on the 'family noticeboard' included the name, address and telephone number for the local safeguarding adults unit. Where concerns had been raised they were appropriately investigated and remedial action was taken.

The registered manager told us that staffing levels were based on levels of dependency at the service, and that this was regularly reviewed. Staff were visible throughout the service during the inspection, and where people needed particular assistance with moving and handling there were enough staff to allow this to be done in a relaxed and unhurried way. People received support in a timely way, and the few call alarms we heard were responded to quickly.

The service had a robust recruitment process. This included a written application, interview, Disclosure and Barring Service (DBS) checks, references from previous employers and proof of identity. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

There was a business continuity file at the front entrance with important information about people, services and support that staff could access in the event of an emergency. It included an easy to follow 'Incident Flow Chart' to assist staff with decision making in a number of different emergencies and had guidance on 'critical activities' such as providing warmth, drinks, food and medicines. There were also specific personal emergency evacuation plans (PEEPS) in place which included information on people's care needs, mobility, medicine and the contact details of family members and social workers. These documents were stored in an easily accessible grab bag which also contained emergency warmth blankets and identity bracelets detailing people's names and relevant telephone numbers.

We looked at the management of medicines. The service had up-to-date policies and procedures in place, which were regularly reviewed, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines that require extra checks and special storage arrangements because of their potential for misuse. The controlled drugs book was in good order and medicines were clearly recorded. We saw the balance remaining was checked against the amount in

Good

Is the service safe?

the pack/bottle on each administration and also a weekly check of stock balances should have been undertaken. However, we saw more recently that the check of stock balances was undertaken on a monthly basis. We spoke to the nurse about this and were told that this would be undertaken weekly forthwith. We looked at a sample of six medicines and found they were all in date and stored appropriately. We saw an appropriate level of stock stored in cupboards. We reviewed a sample of MAR forms and found that they were completed correctly. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We did not see any topical MARs but the registered manager told us that they were used.

The registered manager told us staff responsible for administering medicines had a competency assessment every six months. They advised if there were any concerns or incidents then it would be completed more frequently. We reviewed these for three staff who administered medicines and noted they were thorough and clearly recorded.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager understood the DoLS process and was able to explain how it was used at the service. At the time of this inspection 22 DoLS applications had been authorised by the local authority. This meant the home was working collaboratively with the relevant authorities to ensure people's best interests were protected without compromising their rights.

The registered manager had a file recording all DoLS, this included a matrix identifying when the original DoLS application was made, when the outcome was received, confirmation of CQC notification and also the date the DoLS was due for renewal. The system was clear and easily accessible should there be any queries in relation to people's mental capacity assessments.

As part of each person's DoLS authorisation a relevant person representative (RPR) was also appointed. A RPR is generally a friend or family member who will ensure the rights of the person being deprived of their liberty was protected. We saw all RPR's appointed were clearly recorded so they could be involved in the planning of each person's care.

The home provided mandatory training for all staff members which was delivered face to face. We saw all training was up to date and a refresher program was in place to ensure the training did not expire. Mandatory training included fire safety awareness, caring for people with dementia, safeguarding adults and health and safety. In addition to the mandatory training course's staff were supported to gain further qualifications in relation to their role. For example, one person had a level three certificate in the principles of end of life care. One member of staff told us, "The home will pay for training, the training is getting better."

When new staff started with the organisation they had a clear induction process and as part of this they were assigned a mentor to support them. Clear documentation was available to record people's progress in the induction process, this included being signed off in key areas such as personal development, implementing duty of care and safeguarding in health and social care. We noted the induction process was linked to the previous skills for care framework, now known as the care certificate.

The provider took over the service and registered it in October 2014. The registered manager told us they were waiting for the service to be operating a year under the new provider to start the new appraisals, they had a plan to start conducting these during September and October 2015. We saw that staff received regular supervision. Prior to supervision staff had a form which they filled in which included questions in relation to safeguarding, whistleblowing and any training needs. Additional information was then completed by the supervisor following the supervision discussions. We received five staff files and saw the supervision for each person was clearly recorded with the conversations that had took place. Staff told us they were being offered support and that their individual needs were being met. One said, "We discussed goals, ambitions, the home and any issues."

All staff received training in food hygiene which included correct food handling and cross contamination of food which was important for people with food allergies. A menu for the day was displayed on the 'resident's noticeboard'. This included two choices of main meal at lunch time and a hot and cold option at tea time. In between the set meal times there were mid-afternoon snacks which on the day of our inspection included homemade scones. The service also had snack stations containing fruit, water and juice. We saw the cook walking round the rooms and asking people what they wanted later in the day and if they had liked their other meals. A member of staff said, "He always asks, but we check again later in case people forget". We saw that staff asked people what they would like to eat even though they had a list of their choices.

We observed the meal time experience in both dining rooms. We saw that it was a calm environment and that people looked relaxed and happy. One person said to a member of staff, "Service with a smile." People were encouraged to be independent but were supported wherever required. Where this was required, we saw staff help people in a caring, discrete and conversational way. For example, we saw one member of staff say, "Would you like a bit of help with that? Shall I sit down with you and give you a hand?"

Good

Is the service effective?

Some people chose to have their lunch time meal in their bedrooms. We saw they were encouraged by staff to be seated in suitable positions to eat and were checked on regularly to ensure they were safe and if they required any support. People told us they enjoyed the food on offer. One said, “The food is good, all cooked here, and you have a choice.” Another told us, “The food on offer is good.” One visitor said, “The food is good, he'd graze all day if you let him.”

We saw the provider had made an effort to ensure the environment was suitable for people living with dementia. The upstairs lounge included a tree with branches of coloured balls which changed on a regular basis. One staff member told us how it was really good for people as sensory stimulation; they explained how some people liked to watch the tree whilst others liked to touch it. The walls had also been decorated in various themes with memorabilia and objects secured against the wall for people to observe and touch. For example, one wall had been decorated in a summer theme with fake grass and a deck chair, all of which were different textures for people to explore.

Care plans included details of appointments with and visits by health and social care professionals such as the General Practitioner (GP) and the podiatrist. We saw that Emergency Health Care Plans (EHCP) were in place where appropriate. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems. This meant that information was available to inform staff of the person’s wishes so that they could be met.”

Good

Is the service caring?

Our findings

People were treated with dignity and respect. Staff addressed people by their preferred name, and encouraged them to attempt things themselves before asking whether they needed support. One member of staff told us, “I think everyone deserves respect. We always give people a choice.” Staff spoke to people in passing even when they were not directly providing support. One member of staff said, “Before I start I like to go to every individual and say good morning.” Another said, “When [the provider] visits she goes to say hello to the people that live here before she comes to us.” We observed staff knocking on doors and waiting before entering, ensuring people’s privacy was respected. Staff were respectful in their approach, treating people with dignity and courtesy. Staff described and explained the care and support they were giving before they began so that people understood what was happening. During the inspection a person had a new wheelchair delivered. The engineer and staff took time to explain to the person and their family how it worked and should be used in a patient and caring way.

The service provided care in a homely manner. We observed staff pausing to talk to people and giving them reassurance and company throughout the day. Staff knew the people they were supporting well and delivered care in a positive and enhancing way. For example, when people asked to watch a film staff were able to recognise what they were likely to enjoy. One person said, “It's a happy house this.” Another said, “[Staff] treat you like family, very kind to me.” A third told us, “It's lovely here. The girls are so kind, they are very good to me.” We observed staff supporting a person who was confined to bed in caring and respectful way. The person said, “It's so comfortable here and that's the most important thing, the girls are kind”. Relatives also described staff as very caring. One said, “The girls are wonderful, they do so much extra for her.” Another said, “We are very happy with her care and the girls are lovely with her.” A third told us, “I am very happy with the care. I looked at two homes locally but this was the best by far.”

Care plans included people’s individual views and preferences. They contained information about people’s life histories, their likes and dislikes and how they enjoyed spending their time. This information supported staff’s understanding of people’s histories and lifestyles and enabled them to better respond to their needs and enhance their enjoyment of life.

Care plans included information on how to support people’s privacy and dignity. For example one person was a private man and this was clearly recorded. The care plans for personal care detailed what privacy meant to the person and how staff were to maintain it. It indicated what support was needed, but also when staff needed to take a step back and leave the person to protect their dignity.

Nobody was using an advocate at the service at the time of our inspection. The provider’s policies included reference to the availability of advocacy support. There was a ‘family noticeboard’ in reception which listed six different agencies that were available in the area that could provide advocacy support if required. There was also a definition on advocacy so it was clear for people what support could be offered.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People's individual needs had been assessed before they moved to the home. We saw that people's families were involved in that process. The assessments were used to design plans of care for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs. The care plans were detailed and provided guidance for staff about how to support each person with their specific needs. People's care records were personalised to reflect their individual preferences, support and how their independence could be promoted. Care plans were thorough and clearly explained the risks identified for each person and the care required. Where people had capacity this was clearly documented and examples were given on how the person might express their decisions or whether they would need to be supported to communicate. Where people had healthcare needs that needed to be regularly reviewed, signs and symptoms were clearly documented and the plans contained details of what action to take.

Care plans were detailed and contained specific information on the kind of care people wanted. There was evidence that they had been evaluated and reviewed and were up to date and reflected the needs of people. For example, we saw there was a sleeping care plan in place which included when the person retired to bed, what time they usually got up, and information on their preferences such as having a bedside light they wanted left on or if wanted staff to check on them every two hours. Staff recognised the importance of involving people in decisions about their own care. One member of staff said, "You get to know preferences by talking to them, their friends and family. We always try to include the person, even if they haven't got capacity."

Relatives told us that they felt involved in people's care. One visitor said, "We were consulted about everything, my sisters have been to all the care plan meetings and reviews. When our [relative] fell ill recently and they acted immediately… it gives you such confidence in leaving her with them." Another said, "We were consulted about her care plan, and there are meetings. They let us know immediately if something is wrong." A third said, "We have been fully consulted about all the care plans and assessments, these are still on going. We were really worried about moving him but we are very happy with him being here, and he has settled well."

The service had an activities co-ordinator and offered a wide range of activities. The activities co-ordinator ensured they knew people and their preferences when planning activities, and used care plans to ensure there was something appropriate available for everyone. They told us, "I prefer to look through notes and care plans before talking to someone." Each person had an individual activity plan and this was used to record people's preferences to ensure they felt involved in activities. People living with dementia were encouraged to participate in activities, and where this occurred it was recorded so further such activities could be planned. A photographic record was kept of activities, and a written review was done for some people which detailed the levels of participation and any feedback received. We asked why this was not done for all activities, and the activities co-ordinator told us, "We ask residents for feedback, good and bad. Then I ask a few days later and remember it for the next occasion."

Information on how to make a complaint was available on notice boards throughout the home, in people's bedroom, in the provider's statement of purpose and also in the service user guide which was available in four different languages. We reviewed the complaints log and noted a clear audit trail was available, including successful outcome. People we spoke to told us they would be comfortable raising any concerns, either with the staff members or the registered manager.

Good

Is the service well-led?

Our findings

A satisfaction survey had been carried out since the provider took over the service in October 2014. This included questions on whether the home was meeting people's care needs, whether staff listened to and asked what people needed and whether people felt informed of changes within the home. Six people had responded and 10 family members had filled in the survey on behalf of people living at Stapleton House. We saw all the answers selected were positive.

There were regular 'resident and family' meetings, and people and relatives we spoke to said they received invitations to these. One person said, "We have meetings to air our views. My family can come in whenever they want." Relatives told us that they were asked their opinions when they attended meetings and that the registered manager was approachable. One relative said, "When I have seen something I am not happy with I just speak to the manager, I even have her home number."

Staff meetings took place and staff felt confident in raising issues for discussion. The meetings were used to share information and ideas on future care planning. One member of staff said, "A few weeks ago we discussed staffing levels, skill mix and revalidation." Another said, "There's enough support, night staff and day staff chat and stay back a bit and at handovers. Now well supported, the management listen, they implement things and are open to things and if have an idea they will sort it."

The registered manager and provider both completed audits and checks on a regular basis. There were lead roles called 'champions' in the home who had their own responsibilities for quality assurance in areas including domestic, maintenance and kitchen. The registered manager completed a monthly check on all of these areas to ensure they were up to date and accurate. The provider told us, "The initial challenge was to get nurses to spread knowledge. Now we are getting champions to spend time spreading knowledge and working to get them to spend time on handover to spread knowledge. We are also trying to get champions to have additional training."

We reviewed a health and safety checklist that was completed on a monthly basis. This included a large volume of areas including water and surface temperatures, lighting, moving and handling and clinical waste. The provider also completed a monthly visited which they documented their findings. We saw that where any actions had been identified from visits or audits these were completed and recorded promptly.

The registered manager completed monthly audits on people's care plans. Following each audit an action log was completed which indicated who was responsible for any action required. The action log was reviewed by the registered manager and a clear record was kept of any required action taken. Staff described a positive and supportive culture. One member of staff told us, "I feel supported by management. I feel like I could go to [the registered manager] with any issues and know I could approach them with anything. [The provider] makes a point of saying hello." Another said, "I definitely feel supported by management. I wouldn't do the job if I didn't." Staff described a strong sense of team work at the service. One said, "Staff get on very well with the residents, staff support each other it's a good team". The registered manager said, "We used to be part of a big group but are now independent, so much better now. It fascinates me when the owner comes in, she just walks round the home and says hello to everybody, before she comes to me, so different, you never saw management do that before." People and their relatives told us that the registered manager and the provider were a "familiar" presence around the service and knew people and their families. The provider said, "My aim is to be around when the manager isn't" and "We speak every day, any time we call each other."