Stonecross Care Home (Kendal) Ltd

Stonecross Care Centre

Inspection report

107 Milnthorpe Road
Kendal
Cumbria
LA9 5HH

Tel: 01539232954

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11 December 2015

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 3 and 11 December 2015. This was the first inspection since the home was registered in August 2015.

There was a registered manager in post. A registered manager is a person who has registered with the (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 2008 and associated Regulations about how the service is run.

During this inspection we found breaches of Regulation 12 Safe care and treatment and of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some of the incidents should have been reported to us (CQC) but the provider had not done so. This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

Stonecross Care Centre is a residential care home that provides personal care and accommodation for up to 32 people. Accommodation is provided over three floors and there is a lift to access each level. The home is located close to the town centre of Kendal. There is a secure garden that was being developed at the time of the inspection for people living there to use and some car parking.

There were sufficient numbers of suitable staff to meet people's needs and promote people's safety. The level of staffing observed on the day of the inspection ensured that people had their needs met in a timely manner.

Medications and the management of them was not always done in a safe manner.

People living in the home and relatives spoke highly of the staff and were happy with their care and support.

Staff displayed a caring and interactive approach with people and they were treated with respect. People dignity and privacy were promoted.

Some staff had commenced working without all of the required training skills to meet peoples needs safely. We recommended that the induction training was delivered in line with the company's training policy and procedures. We also recommended that further training on the requirements relating to the MCA and DoLs is provided.

Assessments made prior to people being admitted to the home lacked vital information about peoples individual care needs.

Care plans and risk assessments made were not always accurate about the needs of people's health and support that they required.

People were supported with their nutritional needs but where someone had significant weight loss referrals to healthcare professionals were not always made.

People were given opportunities to be involved in hobbies and interests that were important to them.

The provider had a complaints procedure available for people who used the service. People who used the service and their families felt able to raise any concerns they might have with the registered provider, registered manager or any other staff members.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People were not always protected against abuse because incidents had not been reported to the appropriate authorities.

Medicines were not always managed or stored safely.

Risk assessments were not always reflective of people's needs.

People told us they felt safe and well cared for in this home.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff had commenced working without the appropriate training.

Consent to care and treatment was not always obtained appropriately as checks about the rights to make decisions on behalf of people had not been confirmed

People had their nutritional needs assessed and received appropriate levels of support to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and their dignity was
respected.

People were supported to access advocacy services should they need to.

People's wishes and preferences had been made clear in their records about what their decisions were for end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive

Information in people's care records did not always accurately reflect their needs.

Where people required support from other health professionals they had not always been referred.

We saw there were activities which people took part in.

People knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Notifiable incidents about injuries had not been reported to CQC as required by the regulations.

There were no effective processes in place to monitor the quality of the service.

Concerns relating the safety and wellbeing of people had not always been appropriately recognised or recorded.

Stonecross Care Centre

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 was 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.

Prior to the inspection we had received some information of concern about peoples care and treatment and we brought forward the date of the original scheduled inspection. This inspection took place on 3 and 11 December 2015 and was unannounced. The initial inspection team consisted of two adult social care inspectors and the second visit was conducted by the lead inspector for the service.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. We planned the inspection using this information.

During the inspection we spoke with five people who lived in the home. Some of the people using the service were living with dementia and we were not able to speak with them. We spoke with six relatives who were visiting the home. We also spoke with four members of care staff, the cook, domestic and administration staff, the registered manager and the registered provider.

We observed care, support and the interactions between staff and people in the communal areas of the home. We looked at the kitchen, communal areas, bathrooms and with permission some people's bedrooms. We looked at seven care files and also looked at a range of records about people's care and how the home was managed

We looked at the staff files for five staff that had been recruited. These included some details of recruitment, induction, training and personal development.

Inadequate

Is the service safe?

Our findings

People who used the service that we spoke with told us they felt safe and did not have any concerns about the care they received. One person said "I do feel safe here, the staff are great.'' Relatives we spoke with told us they had no concerns about the safety of people at the home. One person told us " I haven't seen my relative as happy as this in a long time.''

We looked at the records of medicines and their management and care plans relating to the use of medicines. We observed staff handling medicines and spoke with senior care staff about medicines procedures and practices. During the inspection we found the medicines trolley had been left unsupervised and unlocked in an area where people could easily access the medicines. We also found that the numbers of some medication was not accurate in relation to the amount of medication that had been given. The room where medicines were stored was not ventilated and the room temperature was excessive. The fridge used for the storage of some medications had not had it's temperature monitored and was not running at the correct temperature recommended.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the way in which medicines and risks were managed care and treatment was not provided in a safe way.

We saw that some hazards to individuals' safety had not always been assessed accurately and measures had not been recorded or put in place to reduce or manage the risks identified. For example where people had fallen frequently their care records had not been reviewed to reflect any changes that may be required to prevent further falls.

On the first day of the inspection we found that the equipment available to support the moving and handling of people was not suitable for supporting people if they fell to the floor. The provider took action to address this matter at the time of the inspection.

Staff told us, and records we looked at confirmed, they had received some training in the safeguarding of adults. Care staff we spoke with could tell us who they should report any concerns or suspicions of abuse to. However we found that incidents that had caused harm to people had not been reported as a safeguarding concern to the appropriate authorities by the registered manager. We have dealt with this matter in the domain of well led.

The home had recently opened and was appropriately furnished and decorated taking into consideration the needs of people who were living with dementia. We recognised that good practice had been referred to in the way that colours, contrasts, virtual décor and signage had used. However we did find that some of the door security systems were not practical in allowing freedom of movement in some areas of the home. The provider took action to address this matter at the time of the inspection.

People who used the service and the relatives we spoke with said they felt there was sufficient staff to

provide the support people needed. We observed throughout the day that people had their needs met in a timely manner and that staff had time to support group and individual activities.

There was a whistle blowing policy that was available to all staff and details of how to whistle blow. Care staff we spoke with were aware of the policy. One said "I know I can report anything I have concerns about." The policy contained contact details for the local authorities and the Care Quality Commission.

We looked at five staff files for recruitment and saw that the necessary checks on employment had been completed. References had been sought and we noted that they were usually from the most recent previous employer in accordance with the homes recruitment policy. Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had been conducted.

Requires Improvement

Is the service effective?

Our findings

People who lived in the home told us that they enjoyed the meals provided. One person told us, "The food is very good and there's plenty of it." Another person we spoke with told us, ''The food is very good and we always get a choice.''

The staff we spoke with told us that they had received some in house training. We saw that some key principles in training had not been completed during the induction period of employment. We could not see how competencies had been checked to confirm that staff had the correct skills. The quality and variety of training did not ensure that staff had received sufficient training to provide them with the skills to effectively perform their work. For example practical moving and handling training. The induction training in practise did not match with the homes policy and procedures for staff training.

Where some people lacked capacity to make certain decisions there were no records of any best interest meetings recorded. Some of the care plans we looked at had not been formally consented to by the appropriate person. This meant records relating to care, decision making and best interest decisions were not always scrutinised and consented to by the appropriate people.

The registered manager and some senior staff did not demonstrate sound knowledge or understanding of the Mental Capacity Act 2005 (MCA) in relation to the requirements around consent and decision making. Training records showed that most staff had completed on line training relating to the MCA 2005 and Depravation of Liberties Safeguards (DoLS).

We observed some people needed support from staff to eat. People received the right level of assistance they needed to eat and to drink. We saw that this was provided in a patient and discreet way. We spoke with the cook who could tell us about the individual's different dietary requirements and any special requirements.

All the staff we spoke with said they felt they were supported by the senior care staff and registered manager. However we did not see that all staff had regular formal supervision meetings where their practice was discussed and they could raise any concerns.

We recommend that the induction training was delivered in line with the company's training policy and procedures.

We recommend that further training on the requirements relating to the MCA and DoLs is provided.

Good

Is the service caring?

Our findings

People we spoke with lived and visited at Stonecross Care Centre they told us they were very happy with the care and support they and their relatives received. Some of the comments included, "The staff are lovely." One person told us, ''The staff are great bunch and work hard."

We saw from the interactions that staff had with people living in the home that they knew people well. Staff knew the life stories of people in the home and were aware of their preferences. We heard staff talking to people about families and friends. We observed that staff interacted with kindness and were respectful of people.

People could access advocacy arrangements if they needed to. An advocate is a person who is independent of the home and who supports a person to share their views and wishes. We saw that information was available in information leaflets in the home for other services that might help people independently.

We observed staff knock before entering people's rooms. We saw that people were asked in a discreet way if they wanted to go to the toilet. Staff maintained people's personal dignity when assisting them with mobility and when using mobility equipment they needed. Bedrooms we saw had been personalised with people's own belongings, such as personal furniture, photographs and ornaments to help people to feel at home. There were policies in place relating to privacy and dignity as well as on line training for staff to complete.

We saw that some people's treatment wishes had been made clear in their records about what their end of life preferences were. The care records contained information about the care people would like to receive at the end of their lives and who they would like to be involved in their care. This was to ensure people who could be involved with planning end of life care were cared for in line with their wishes and beliefs at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

We asked the people who used the service whether they felt they could easily raise concerns if they had any. One person told us, "I've never had to make any complaints." Another person told us if they had a problem they felt more than happy to raise it directly with any of the staff. We asked to see if any formal complaints had been made however the complaints log was not available at the time of the inspection. The provider told us they preferred to manage people's concerns or complaints as soosn as they arise.

Care plans were not always reflective of people's current needs. This has been highlighted in the safe domain where pre admission assessments had not always been accurate. Although we saw a process was in place for care plans to be reviewed some changes in people's needs had not always been noted. This meant that the plans for caring and supporting peoples needs were not always accurate.

We did not see effective working with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services. For example where people had repeated falls we did not see any referrals to other health professionals who could support. For another person although they had been visited by the community nurse on the day of our inspection we noted new information about their health had not been shared.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Vital information relating to peoples care was not always recorded or shared with relevant people to ensure that safe care and treatment was being delivered.

There were no restrictions on when visitors could visit their relatives in the home. One person who visited the home every day told us, ''It's a great place and we are extremely happy with the care our relative receives. Whatever we ask about it's dealt with.

There were some activities for people to get involved in and we observed people doing individual activities and a group activity took place where people were supported by staff to join in.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and registered provider had not always notified the appropriate authorities following incidents that affected the welfare and safety of the people who use the service. This also included failing to notify the CQC of incidents requiring another health professional to deal with them.

This is a breach of Regulation18 Notifications of other incidents of the Care Quality Commission (Registration) Regulations 2009. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We did not see any formal systems in place where people and their relatives were given opportunities to share their views about the service they received.

We did not see any systems in place to help monitor the standard and quality of the service. There were gaps in staff personnel records and people's personal care records were not always reflective of their actual needs. Accidents and incidents had not been routinely reviewed and evaluated to help identify and reduce potential risks to people who lived and worked at this service.

Over sight of the staff training records had not been maintained and induction training had not always been completed. Some staff could tell us about the training they had received but this had not always been recorded.

We did not see records to show that staff had received regular supervision to support their daily practise and give them an opportunity to raise any concerns they may have.

Although we saw records showing the home worked in partnership with some professionals we found that there were other people who would have benefited from the input of other health professionals such as an occupational therapist and these had not been identified. Where required some people received support from community nurses and the home worked with the community nursing team to meet people's needs.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (regulated activities) regulations 2014. This was because the systems and processes to ensure compliance with the Regulations were not established and operated effectively to identify where the quality and safety of the service may be affected.

We spoke at length with the provider during the inspection process. They told us that they wanted their home to provide a warm family atmosphere for people who used the service. They were keen to ensure that the environment was correctly adapted to meet peoples needs and that the staff provided a high standard of service. They acknowledged that the registered manager had not implemented their vision correctly. They told us that they had engaged the service of a mentor experience in health and social care to help them ensure that the vision they had would be implemented.

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 12 HSCA RA Regulations 2014 Safe care and treatment This was because care and treatment was not always provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This was because systems or processes were not effectively established to ensure compliance with all of the requirements withn the regulations.