Brookfield Care

Stuart House Residential Home

Inspection report

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Hornsea
East Yorkshire
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Ratings

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

Overall summary

This inspection took place on 2 September 2015 and was unannounced. We previously visited the service on 27 August 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 19 older people, some of whom may be living with dementia. On the day of the inspection there were 17 people living at the home. The home is located in Hornsea, a seaside town in the East Riding of Yorkshire. It is close to town centre amenities and the sea front, and is on good transport routes.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 4 December 2014. A registered manager is a person who

Summary of findings

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 told us that they felt safe living at Stuart House and we saw that the premises had been maintained in a safe condition.

We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Although managers and some staff had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager needed to be prompted to submit applications to the local authority in respect of some people who were possibly being deprived of their liberty. People were supported to make their own decisions when they had capacity to do so, and best interest meetings were held when people did not have the capacity to make decisions for themselves. However, best interest meeting records were not specific about the decision being made.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records evidenced that most staff had completed training that was considered to be essential by the home and that most staff had achieved a National Vocational Qualification (NVQ).

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with older people had been employed. We saw that there were sufficient numbers of staff on duty to meet people's individual needs.

Staff who had responsibility for the administration of medication had completed appropriate training. Medicines were administered safely by staff and the arrangements for storage and recording were robust, although some minor improvements were needed.

People's nutritional needs had been assessed and people told us that their special diets were catered for, and that they were happy with the meals provided at the home. We saw there was a choice available at each mealtime, and that people had been consulted about the choices available on the home's menu.

People told us that staff were caring and we observed that staff had a caring and supportive attitude towards people; this was supported by the relatives and care professionals who we spoke with.

There were systems in place to seek feedback from people who lived at the home and relatives / visitors. There had been no formal complaints made to the home during the previous twelve months but there were systems in place to manage complaints if they were received.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas that needed to improve in respect of safety and people's care. However, more effort could have been made to analyse the outcome of audits and surveys so that there was a record of the improvements that had been made.

We saw that, on occasions, incidents that had occurred at the home had been used as a learning opportunity for staff.

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 is safe.

Staff had received training on safeguarding adults from abuse and told us they would use the whistle blowing policy if needed.

The arrangements in place for the management of medicines were satisfactory.

We found that staff were recruited following safe policies and procedures, and that there were sufficient numbers of staff employed to meet the needs of people who lived at the home.

Good

Is the service effective?
The service is not always effective.

Managers and staff had an understanding of the requirements of the Deprivation of Liberty Safeguards (DoLS) although managers needed prompting to submit applications to the local authority for their consideration.

Best interest meetings had been held to assist people with decision making but we noted that the records were not specific about the decisions being made.

Staff undertook training that equipped them with the skills they needed to carry out their roles, although more emphasis needed to be placed on dementia awareness training.

People's nutritional needs were assessed and met, and people told us they had access to health care professionals when required.

Requires improvement

Is the service caring?
The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and that people's individual care needs were understood by staff.

People were encouraged to be as independent as possible, with support from staff.

Good

Is the service responsive?
The service is responsive to people's needs.

Good

Summary of findings

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and although no complaints had been received, we saw that people were invited to give feedback on the service provided by the home.

Is the service well-led?

Good 

The service is well led.

The management arrangements at the home were satisfactory.

There were sufficient opportunities for people who lived at the home, relatives and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that the systems in place

were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Stuart House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 2 September 2015 and was unannounced. The inspection team consisted of an adult social care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. We also contacted a small number of health and social care professionals before the inspection and we received feedback from three of the people we contacted.

On the day of the inspection we spoke with six people who lived at the home, two relatives or friends, four members of staff and the deputy manager. The registered manager was on leave on the day of the inspection and they forwarded some information to us following the inspection.

We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with six people who lived at Stuart House and they all told us they felt safe living at the home. One person said, "In general I feel safe in the home; I have never been mistreated or shouted at." We saw the minutes of the residents meeting held in May 2015. These evidenced that people were asked if they felt safe living at the home and they all confirmed that they did.

We asked staff how they kept people safe and one member of staff told us that they followed risk assessments and had appropriate training, for example, health and safety. Another staff member told us, "Making sure the floors are clear and there is nothing to trip over." They went on to describe how they checked the safety of bed rails and ensured drinks were not too hot. They said that, by looking at care plans and risk assessments, they were aware of the risks to each individual.

Staff used a 'swipe card' to gain access via the front door and visitors had to ring the doorbell to enter the home. This meant that people who lived at the home could not leave the premises unnoticed. A care professional told us about the arrangements in place to ensure that a person who went out into the community on a regular basis was kept safe by being provided with a mobile telephone. We also observed that people were able to move around the home and garden without restriction when risk assessments evidenced that this was safe for the individual concerned.

We saw that care plans listed the risks associated with each person's care. People had risk assessment in place about nutrition, the use of bed rails, pressure care and moving and handling. In addition to this, some people had more individual risk assessment in place such as the use of a catheter, choking and allergies. Some risk assessments that we saw did not record a review date so it was not clear whether the information was still valid. However, the deputy manager told us that the risk assessments we saw contained up to date information.

We spoke with the local authority safeguarding adult's team prior to the inspection and they told us they did not have any concerns about this service. Records evidenced that staff completed training on safeguarding adults from abuse as part of their induction training, and that established staff had done further training during 2014 / 5. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager, deputy manager or senior member of staff on duty. Staff also told us that they would not hesitate to use the home's whistle blowing policy if they were concerned about any incidents or care practices at the home. One member of staff told us, "We are massively encouraged to whistle blow if there is a problem. The managers are very approachable."

We saw that some care plans included information about the person's behaviour that could cause them or others harm. The care plans recorded how these should be managed by staff to keep the person safe.

The deputy manager told us that they did not use a dependency tool to determine staffing levels at the home. They explained the staffing levels; there were three care staff on duty from 7.00 am until 3.00 pm and two care staff on duty from 3.00 pm until 11.00 pm each day, with an additional worker on duty from 3.00 pm until 8.00 pm each afternoon / evening. There were two staff on duty overnight. Either the registered manager or deputy manager were on duty in addition to care staff over seven days a week. There was a cook on duty each day, a domestic assistant on duty for three half days a week and a handyman. Care staff were responsible for laundry duties, light domestic chores when the domestic assistant was not at work and preparing tea. However, we observed that care staff spent most of their day concentrating on supporting people who lived at the home.

On the day of the inspection we saw that call bells were responded to promptly and that there was always a staff presence in communal areas of the home. One person spent most of the day in a separate lounge and this meant they received less attention than other people; the reasons for this were explained to us and were recorded in the person's care plan. However, we saw that this person became anxious at times and this caused them to shout out for attention. We discussed this with the deputy manager at the end of the inspection and they agreed they would try different strategies to keep this person occupied in an attempt to reduce their anxiety.

A member of staff told us that there were usually enough staff on duty but added, "We could always use more – it would be nice to do more one to one care." Another member of staff told us that there had been a high staff turnover but staff were "Good at covering shifts." The

registered manager told us that they would arrange for extra staff to be on duty if someone was ill in bed and needed constant attention, for example, if they were receiving end of life care. Also, the registered manager and deputy manager were available to assist care staff if an emergency occurred.

The registered manager also told us that they had recently changed shift times so that night staff worked from 11.00 pm until 8.00 am and day staff worked from 7.00 am until 11.00 pm. This meant that there was one hour between 7.00 – 8.00 am when more staff were on duty. This had been introduced because this was the time when most people chose to get up and there would be sufficient numbers of staff on duty to meet people's individual needs.

We checked the recruitment records for three new members of staff and these evidenced that only people considered suitable to work with older people had been employed. We saw that prospective employees submitted an application form that included their employment history, the names of two employment referees, details of previous relevant training and a declaration about any criminal convictions. We saw that documents confirming the person's identity, two employment references and a Disclosure and Barring Service (DBS) check had been obtained by the registered provider. The DBS service maintains a register of people who have been referred to them because they are considered unsuitable to work with vulnerable groups of people. We noted that some references did not contain the name of the referee or the date; we discussed this with the deputy manager at the end of the inspection and they told us that, although they were aware of who the references were from and what date they had been received, in future they would ensure that this information was recorded on the written reference.

We saw that, on occasions, people started to work at the home before two written references and a DBS check had been obtained. The deputy manager assured us that, until a DBS check had been received, new staff carried out induction training and shadowing shifts but did not work on the rota unsupervised. They were able to show us documents to confirm this, including a shadowing shift form that recorded how well the person had carried out their duties. New staff also signed a document to record that they had received a copy of the staff handbook and the procedures manual. Staff who we spoke with confirmed that robust recruitment procedures had been followed at the time of their employment.

People who lived at the home had personal emergency evacuation plans (PEEPs) in place. These are documents that record the assistance a person would need to be evacuated from the premises, including the equipment they used to mobilise and the level of assistance they would require from staff. There was no contingency plan in place although the deputy manager told us that they had a reciprocal agreement in place with a nearby care home that they would provide emergency accommodation if people had to be evacuated in an emergency. There was a fire risk assessment in place that had been reviewed in January 2015 and the deputy manager told us that they would develop this into a full contingency plan.

There were service certificates in place for the passenger and stair lift maintenance, the fire alarm system and fire extinguishers to ensure that the home remained safe for the people who lived and worked there. We saw that the electrical installation certificate had expired two days prior to the inspection. We discussed this with the registered persons and they told us that they had difficulty contacting their usual contractor. A different contractor had been sourced and had visited the home to assess the work that needed to be carried out. They were due to carry out the work on 12 October 2015. The registered provider agreed to forward a copy of the new electrical installation certificate to the Commission as soon as it had been received.

Day to day maintenance was carried out by the home's handyman, such as checks on window opening restrictors, water temperatures, water safety (in respect of the risk of Legionella), hoists / slings / wheelchairs and a general building inspection. Staff recorded any repairs that were needed in a maintenance book and the handymen signed the book when they had completed the repairs. Fire drills were carried out every few months and weekly checks were carried out on the fire alarm system, emergency lighting, fire doors and smoke alarms.

We saw the records of accidents and incidents. Accident records were held in a person's care plan, in a log book and in a monthly record. The incident report included a description of the incident, whether medical attention was required, if the person was admitted to hospital and any action taken. There was a slips / trips / falls audit checklist

Good

Is the service safe?

in use but we saw this had not been used for some time. However, records evidenced that appropriate referrals had been made to the falls team to request advice when people had suffered regular falls.

Only senior staff administered medication and we saw they had undertaken appropriate training; they told us that they completed this training each year. We observed the administration of medication and saw that this was carried out safely; the senior staff member did not sign medication administration record (MAR) charts until they had seen people take their medication, and people were provided with a drink of water so that they could swallow their tablets or medicine. The member of staff explained to each person what they would be doing and asked them discreetly if they required pain relief medication. There was a protocol in place for the administration of 'as and when required' (PRN) medication.

People told us that they received their medication on time; one person said, "I am on a lot of medications and always get them on time." However, there was no audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. We discussed this with the senior person on duty and the deputy manager, and they told us that they would ensure that they obtained a copy of the person's prescription in future so these checks could be made.

Medication was supplied by the pharmacy in 'Nomad' packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Nomad packs were stored in the medication trolley, which was locked and stored in the medication cupboard. The medication fridge was also stored in the medication cupboard and we saw that the temperature of the cupboard and fridge was taken and recorded most days; there were occasional omissions. We saw that items other than medicines were stored in the medication fridge and these were removed on the day of the inspection.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. Controlled drugs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We checked MAR charts that were used to record the administration of other medication and noted that there were a very small number of gaps in recording and that codes were used appropriately. We noted that two staff had not signed hand written entries on MAR charts; this is considered to be good practice to reduce the risk of transcribing errors occurring. When medication had been stopped following consultation with the person's GP this had been recorded on the MAR chart; these records would be improved if the date the instruction had been received from the GP was recorded so that this information could be cross referenced with information in the person's care plan.

There was an effective stock control system in place and a record of weekly drug trolley cleaning. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Training records evidenced that eleven staff had attended training on the MCA and nine staff had attended training on DoLS. Discussion with the deputy manager evidenced that the registered and deputy managers had also attended this training. They told us that no applications had been submitted to the local authority as yet, but they informed us after the inspection that they had held discussions with the local authority. They had identified three people who needed applications to be submitted for consideration and they were in the process of writing the applications.

A person's capacity to make decisions had been assessed and the deputy manager told us that best interest meetings would be arranged as needed. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. However, we saw evidence of best interest meetings in care plans and noted that these were not time and decision specific; they did not record the decision being made or the date it was being made. We discussed this with the deputy manager and they told us they would record more specific information in future.

Training records evidenced that only one member of staff had undertaken training on dementia awareness; this was considered to be 'optional' training for staff rather than essential. However, we could see that attempts had been made to raise awareness; there were various charts displayed around the home that advised people to think about how they communicated with older people and people who were living with dementia, such as "Adapt your language – if you need to use simple language try to avoid it sounding childish" and "Listening is more than just hearing."

We recommend that staff have specific training on dementia awareness as some people at the home are living with dementia.

We asked staff if people could find their way around the home and they told us that people did not have difficulty finding toilets, bathrooms or their bedroom. People's names were printed on their bedroom door but there were no pictorial aids to help people with cognitive difficulties.

During the day we noted saw there was an area close to the back door that could have created a trip hazard to people with cognitive difficulties; the deputy manager told us that they would ask the handyman to make this safe as a matter of urgency.

There was a clearly written and pictorial calendar and weather board on display in the hall but there were no rummage boxes, memory stimulation aids or memorabilia to assist people who were living with dementia.

We recommend that people living with dementia are provided with signage and other memory aids to assist them with stimulation and recognition.

We saw in care plans that people had been asked to sign a document to record their consent to staff administering their medication, taking photographs and being weighed.

Staff told us that they encouraged people to make choices, such as what they would like to eat and drink and what clothes they would like to wear. One member of staff told us they sprayed perfume in the air to help people decide which one they wanted to wear. On the day of the inspection we observed a care worker going to each person to ask them what they would like for their tea. People who lived at the home told us about the choices they made. Comments included, "I go to bed when I want to and I get up when I am ready" and "Most of the time you can do what you want. I get up when I want to and go to bed very late. I have an en-suite so I can shower when I want." However, one person told us, "We can ask staff if we want a bath or shower. Sometimes we are told we can only have one on a certain day." We discussed this with staff and they told us that there was a bath / shower rota in place but people could request a bath or shower at any time.

Staff told us they had thorough induction training when they were new in post and that this included shadowing experienced care workers. We saw the induction and training records for three members of staff and these evidenced that induction training consisted of an

Is the service effective?

orientation to the home, as well as training on topics the home considered to be essential. These topics included fire safety, safeguarding adults from abuse, moving and handling and health and safety.

Each member of staff had an individual training record in place that recorded the training they had completed at previous workplaces and at Stuart House. We saw that, in addition to essential training, some staff had completed training on the topics of infection control, equality and diversity, care planning, challenging behaviour, DoLS and MCA. The registered manager told us in the PIR document that 13 of the 17 care staff had also completed a National Vocational Qualification (NVQ).

Staff who we spoke with confirmed that they received training opportunities. One member of staff told us they had completed training on MCA / DoLS, health and safety, safeguarding adults from abuse and moving and handling during the previous year. Another member of staff told us they had completed NVQ Level 2 and moving and handling training during the previous year. We saw that the minutes of the staff meeting in May 2015 recorded that staff had to complete all essential training by 18 May 2015. This evidenced that staff were offered a variety of training courses to keep their practice up to date.

People who lived at the home and relatives / visitors spoke highly of staff who worked at the home and told us that staff seemed to have the skills they needed to carry out their role.

The registered manager told us in the PIR document that 'compliance supervisions' were going to be introduced for staff. We saw examples of these in staff records; as well as an opportunity for staff to discuss any concerns, their training needs and issues about people who lived at the home, they had been required to undertake on-line tests on specific topics to check that they remained competent. Staff told us they felt well supported and that they could speak to the registered manager or deputy manager at any time. One staff member said, "(The deputy manager) is easy to talk to. If you don't know something, they don't patronise you."

People who lived at the home told us that they had good access to GPs and other health care professionals. One person told us, "If I needed a doctor, I know staff would take care of it for me." Visitors told us that they were kept informed of any changes to their relative's health and well-being. One relative told us, "I have no problems or worries as I know they would organise any care that she needed."

There was a record of any contact people had with health care professionals; this included the date, the reason for the contact and the outcome, plus a record of any advice given. We noted that advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs.

People had information in place that was ready for them to take to hospital appointments or admissions when they were unable to verbally communicate their needs to hospital staff. This meant that hospital staff would have access to information about the person's individual care and support needs.

We observed the lunchtime experience and saw that the meal served looked appetising and hot. We saw that some people chose to wear an apron to protect their clothes. People were invited by staff to sit at the dining table and some people chose to stay in the conservatory to eat their meal. We saw that people did not have to wait long to be served. One person was assisted to eat their meal by a member of staff and this was done in a caring and considerate manner. The staff member did not hurry the person but went at their pace.

There was a chalk board in the dining room where the menu of the day could be written and displayed, but we noted there were no pictorial menus available for people with cognitive difficulties. However, we observed that staff offered people choices such as which condiments they would like and what drink they would like, and later in the day we heard staff asking people what they would like for their tea.

People told us they enjoyed the meals prepared at the home. Comments included, "The food is brilliant. We have a fairly set lunch but for tea you get choices", "I enjoyed lunch – it's always nice" and "The cook is very good; they ask what people like. We get choices but if we don't like anything, we would probably have a sandwich." People who had special dietary needs told us that these were met and that "Some lovely meals are prepared for me."

Requires improvement

Is the service effective?

Staff told us that information about people's special dietary needs were recorded in their care plan and that care plans were continually updated. They also told us that there was a list in the kitchen recording people's special diets, or likes and dislikes. One staff member told us that they currently prepared vegetarian and diabetic meals for some of the people who lived at the home. They also told us, if people required a liquidised meal, each component of the meal would be liquidised and presented separately to make it more appealing.

One visitor told us that their relative had a small appetite and there was a particular food she could not tolerate. They were not certain that this had been adhered to by staff at the home. We discussed this with the deputy manager who assured us that this information was recorded in the person's care plan, that all staff were aware of this information and that their special dietary needs were being met.

Although people had a drink at mealtimes, mid-morning and mid-afternoon, we saw that no snacks or drinks were available for people to help themselves to at other times of the day. We discussed this with the registered manager and they told us that some people who lived at the home would eat all day if food was freely available and to safeguard against this, they preferred staff to ask people throughout the day if they would like a drink or snack.

We saw that charts were used to monitor food and fluid intake when this had been identified as an area of risk. These would have been improved if fluid intake had been totalled each day and if there was a record of the action staff should take if the target intake had not been reached. People were also weighed as part of nutritional screening; these records had been well maintained until June 2015 but not during July and August 2015. However, overall people's nutritional intake had been monitored to promote their health and well-being.

Good

Is the service caring?

Our findings

On the day of the inspection we observed that staff had a caring and considerate manner with people who lived at the home and that they knew people's needs well. People who lived at the home told us that staff cared about them and spoke with them in a friendly, polite and respectful way. Comments included, "Staff talk to us kindly" and "I like it here; the staff are nice to me. Staff speak nicely to me – they never get angry." A member of staff told us, "They say you shouldn't get attached – staff here are brilliant – they always have people's best interests at heart."

We observed positive interactions between people who lived at the home and staff throughout the day. We asked people if their care was centred on them, and they responded positively. One person said, "There are excellent staff – they give me respect. Some are very loving. Some are better than others but they are all good."

Staff told us that they read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships and their likes and dislikes. On the day of the inspection we observed interactions that evidenced staff knew people's individual personalities, needs and wishes. This resulted in people being supported to live their chosen lifestyle.

A social care professional told us that the registered manager was pro-active and had a good knowledge of people's needs. They told us, "She (the manager) always telephones to discuss any concerns or to ask for advice and she appears to work in the residents best interests." When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

People who we spoke with told us that their privacy and dignity was upheld by staff and we observed this on the day of the inspection. People were accommodated in single rooms meaning they had private space where they could receive assistance with personal care or meet family, friends and health care professionals. Staff explained to us how they promoted privacy and dignity by closing doors and knocking on doors before they entered.

On the day of the inspection we saw that staff encouraged and supported people to do things for themselves when they had the ability to do so. Staff described to us how they helped people to maintain their independence. They said that they encouraged them to do as much for themselves as they could. One member of staff told us, "We need to encourage people otherwise they lose ability and skills."

We asked staff about maintaining confidentiality. One person told us that they occasionally overheard conversations that one of the managers might be having with a relative or other staff member that contained confidential information. This was when managers were walking around the home using the telephone. They stressed that this was not intentional but nonetheless there was a risk that people could overhear confidential information. We discussed this with the registered manager who told us they would never have a private conversation in a communal area of the home. However, they said they would ensure that all staff were aware of this.

Although no-one at the home was receiving end of life care, we received positive feedback about the care and support staff had provided when people were at the end of their life. A social care professional told us they were "Very pleased" with the care and support one person received.

Good

Is the service responsive?

Our findings

We reviewed the care plans of four people using the service. We saw that people moved to Stuart House following an assessment of their needs. Care plans and risk assessments documented important information about people's individual support needs as well as their likes, dislikes and personal preferences. Staff recorded a detailed family history of the people using the service with information about the person's early life, work, family, hobbies and interests. We saw that each person's bedroom had a wall-chart called 'About Me' which showed easily accessible information about the person, although one visitor told us that the information about their relative needed to be updated. Staff we spoke with said that they felt this was important as it ensured that staff had a quick reference guide to the needs / likes and dislikes of each person in their care. This meant that staff had information to enable them to provide personalised care and support to meet the needs of people using the service.

During the day we observed staff speaking with people using the service in a way that acknowledged their individual needs. One of the people using the service was particularly anxious on the day we visited. We observed staff communicating this information with other carers and asking them to provide additional support and reassurance throughout the day. We saw staff stop what they were doing and make time for this person during the day to provide additional support. This showed us that staff were responsive to the changing needs of people using the service.

Staff told us that they talked about people at handover meetings to ensure they had up to date information. We observed a staff handover meeting. This is where the care team on duty meet with the care team beginning their shift to share information about people using the service and any issues within the home. We saw that staff discussed each person using the service and gave an update about their general wellbeing and particular needs or issues that day. One person using the service had refused to eat or drink much that day and it was communicated that staff needed to make special effort to encourage them to eat and drink. This ensured all staff had up-to-date information to enable them to provide personalised support responsive to people's changing needs.

People using the service told us they made choices such as what time they got up or went to bed and choices about what to eat and drink. Comments included, "Most of the time, you can do what you want. I get up when I want to and go to bed very late. I have an en-suite shower so can shower when I want". We observed a member of staff speaking with people to ask them what they would like for tea. We saw another carer talking with people about whether they would like to get their hair cut and nails manicured when the hairdresser visited later that week. This showed that people were able to make choices and that staff routinely listened to the wishes and views of people using the service.

The service did not have a weekly activities schedule. Staff told us that they did not schedule weekly activities as they felt there should be spontaneous activities responding to the wishes of the people using the service. Staff confirmed that they preferred to arrange activities 'on the day'. However, staff told us, "Sometimes we haven't got time to do activities, but we are encouraged to do as much with them as possible."

The deputy manager told us that some people preferred one to one time being spent with them rather than group activities. They planned to produce a photograph album for each person who lived at the home to generate conversation.

The deputy manager showed us a projector and cinema system the home had installed so that they could have 'movie nights' for the people using the service. We were told that these were held as often as people would like, but usually between once and three times per week. Staff told us they also play bowls in the main lounge and board games including snakes and ladders. We saw that the service arranged for a hairdresser to visit and that 'movement to music' classes were held within the home.

We observed one person who used the service asking to use the telephone and staff supporting them with this. Later we saw staff taking the telephone to another person who had received a telephone call. Staff and people using the service told us that there were always lots of visitors and we observed staff welcoming a visitor to the home. This meant people using the service were supported to stay in touch with family and friends.

We saw that visitors called into the home throughout the day and staff told us that some relatives visited every day.

Good

Is the service responsive?

We observed they were made welcome by staff and offered refreshments. It was clear there were good relationships between staff and relatives / visitors. One person told us they visited the home every week and sometimes brought their child in with them; they said that people who lived at the home enjoyed this.

We saw that there was information displayed in the entrance hall about the home's complaints procedure, and encouraging people to give their views and feedback on the service they received.

We asked people who lived at the home if they knew how to express concerns or make a complaint. One person told us, "I have been here a long time and over the years have made plenty of minor complaints, but they have all been dealt with as I would wish."

No complaints had been received by the home during the previous twelve months and the registered manager told us in the PIR document that they had received 27 compliments during the same period. All of the health and social care professionals who we spoke with told us that they had no concerns about the service provided by the home.

A member of staff told us that some people who lived at the home understood how to make a complaint and they would support other people to make a complaint if they thought they had reason to. They said they would try to deal with any minor concerns or complaints themselves. They would then enter the information into the 'manager's book' and the 'handover' notes, or speak directly to the senior member of staff or manager on duty. Staff told us that people's complaints would be listened to and acted upon.

The Commission received information of concern in March 2015 and we asked the registered provider to investigate. They conducted a thorough investigation and we noted that some improvements had been made to the service as a result. For example, two care staff worked the overnight shift and previously there had been occasions when both staff had been male. The registered provider ensured that staff rotas were amended so that only one male care worker was on duty overnight. This meant that if people had expressed a preference to be assisted by a female, this could be accommodated.

Good

Is the service well-led?

Our findings

There was a registered manager in post on the day of this inspection. They had registered with the Commission in December 2014 and had worked at the home previously, so they already knew the staff and people who lived at the home. The registered manager was on leave on the day of the inspection and we were assisted by the deputy manager, who had various responsibilities within the home and was able to assist with the inspection and locate most documents that we required promptly. Records that could not be found were forwarded to us the day following the inspection. Overall, we found that records were well kept, easily accessible and stored securely.

A social care professional spoke positively about the registered manager. They told us, "I have found (the manager) to be approachable and keen to develop her new role."

The deputy manager told us that the culture of the home was one of openness and transparency and that the staff group and managers "Say when something is wrong." A member of staff told us that people who lived at the home were encouraged to be 'themselves'. They said there was a family atmosphere at the home and it was not 'institutionalised'. Another member of staff told us, "I like that it's clean, tidy and homely. We are constantly reminded it's their (the residents) home. It's a nice place to be."

Staff told us they felt the registered manager and deputy manager were strong leaders who 'led by example'. They said that there was always a manager or senior care worker 'on call' so they could contact someone to assist with problem solving. A member of staff told us that there had been a culture at the home of 'day staff versus night staff'. This had been discussed at a staff meeting (we saw these meeting minutes) and a policy had been introduced to promote swapping of shifts so that day staff worked some night shifts and vice versa. The member of staff told us that this had broken down some of the barriers and staff better understood what work people did on different shifts.

The registered persons told us in the PIR document, "The residents simply take absolute priority in every decision and management focus." They said that one example of how people who lived at the home had been involved in decision making was that they had chosen the new lounge furniture. One person who lived at the home told us, "I don't think I would change anything about the home."

We saw the minutes of the residents meeting held in May 2015. Six people attended the meeting and we noted they were asked if they had any complaints. No-one had any complaints but suggestions were made about changes to the menu and about activities. One person commented that they were happy with the re-decoration of their room. The minutes of the meeting also recorded that three people who did not attend the meeting were consulted separately to check that they were happy with the care and support they received. They all told the registered manager that they were happy and had no complaints.

A survey had also been distributed to people who lived at the home and three had been completed. These contained positive comments about the care they received and no concerns had been raised.

One relative told us they had not been invited to relative meetings, but they had recently completed a satisfaction survey. We checked satisfaction surveys that had been returned from relatives in May 2015. Sixteen surveys had been returned and we saw that most responses were either Good or Excellent. There were some very positive comments from relatives, including "Visiting my relative over a number of years I can state that I am very pleased with the ambiance of the home and the kindness and willingness of staff", "I have the utmost respect for the manager and her staff. They are doing an excellent job" and "All excellent – manager and staff all first class. Couldn't ask for better."

Although only a small number of minor concerns about activities and laundry had been raised in 'resident' and visitor surveys, it would have been useful for the responses to be collated and an action plan developed to show that the minor concerns had been listened to and acted upon to improve the service received by people living at the home.

Staff told us that they attended meetings and we saw the minutes of a meeting that had been held on 5 May 2015. We saw that various topics were discussed including cleaning, maintenance, communication, training and the use of mobile phones. The minutes also recorded that there had been a fire drill immediately following the staff meeting. Staff told us that suggestions were listened to but

Good

Is the service well-led?

they were not necessarily 'taken on board', although they said that any safety issues raised were always actioned. They also told us that they would like staff meetings to be held more often, preferably monthly, as they felt this would improve communication. They told us, "Morale seems better after team meetings."

The registered manager and deputy manager carried out a variety of audits to check that the home was being operated in a safe way and that people were receiving safe and effective care. The audits included those for care plans, staff training, slips / trips / falls and medication. We noted that the medication audit recorded any actions that needed to be taken, although there was no record of when these had been completed.

In addition to audits, checklists were completed on cleaning performance, infection outbreaks, safeguarding issues, risk assessments, restraints, and lifts and hoists. Again, some of the checklists recorded minor improvements that needed to be made, but not when these had been actioned. It would be good practice to record when actions had been completed so there was evidence that any identified improvements had been noted and acted on.

Staff told us there had been some learning from incidents at the home. They said any issues would be discussed at staff meetings and at handover meetings. They gave us an example; one person had been provided with a bed rail at the side of the bed. A staff member saw them trying to climb over it. Immediate action was taken; the incident was reported to the registered manager, the bed rail was removed, all staff were informed and care records were amended. Another member of staff told us that a health care professional had reported that they saw staff using moving and handling techniques that they felt were unsuitable. They told us that all staff had been made aware of this and additional training was introduced.

We noted that people who wanted to maintain links with the local community were supported to do so. One person went out most days and accessed amenities in the town centre.