Bupa Care Homes (ANS) Limited

Stamford Care Home

Inspection report

21 Watermill Lane
Upper Edmonton
London
N18 1SH

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1, 2 and 3 February 2017 and was unannounced. During the last inspection on 23 and 24 March 2016 we found the service was in breach of five legal requirements and regulations associated with the Health and Social Care Act 2008. We found that people who used services and others were not protected against the risks associated with their care and treatment. Care and treatment was not always provided in accordance with the Mental Capacity Act 2005 (MCA). We found there were deficiencies related to monitoring of people's nutrition and hydration. There was not a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service. The provider had not notified the Care Quality Commission about significant events affecting people's care and support needs in relation to the outcomes of Deprivation of Liberty Safeguarding (DoLS) outcomes.

Stamford Nursing Centre is registered to provide nursing care and accommodation for a maximum of 90 adults, some of whom may have dementia. There are 27 bedrooms on the ground floor (Oakwood Unit); 30 bedrooms on the first floor (Broomfield Unit); and 33 bedrooms on the second floor (Woodside Unit), which is dedicated to people living with dementia. At this inspection there were 87 people living in the home.

There was a registered manager in place. 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.

Medicines were not being managed safely. We found that some medicines were not stored and disposed safely. People's Medicine Administration Records (MAR's) were not always completed in full or accurately. Medicines were not always administered as prescribed. Medicine audits had failed to identify the issues that we found. We also found that the home improvement plan did not include the findings from an audit carried out by the registered manager.

At this inspection, we found detailed current risk assessments were in place for people using the service. Risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

Significant improvements had been made to ensure that consent to care was obtained from the appropriate person. Care plan specifying best interests needs were in place. Staff had received training on Mental Capacity Act 2005 (MCA) and staff understood the importance of obtaining consent from people.

People received a nutritious diet and enough to eat and drink to meet their individual needs and timely action was taken by the staff when they were concerned about people's health.

Staff training, supervisions and appraisals were monitored and updated regularly. Systems had been

implemented to ensure a better oversight of when staff training, supervisions and appraisals were due.

There were enough staff to meet people's care needs safely and also to provide individualised support in and out of the service. Staff were safely recruited with necessary pre-employment checks carried out.

We found that improved systems were in place to monitor and check the quality of care provided. We received consistently positive feedback from staff regarding the management structure in place and the support they received.

Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. All staff had completed training in safeguarding adults and demonstrated an understanding of types of abuse to look out for and how to raise safeguarding concerns.

Care plans were person centred and reflected what was important to the person. Care plans provided appropriate guidance to enable staff to deliver person centred care in line with people's preferences.

The registered manager and deputy manager were accessible to people and staff who spoke positively about them and felt confident about raising concerns. The provider had quality assurance processes and procedures in place to monitor the quality and safety of people's care.

At this inspection we identified a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to medicines management. 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?

Requires Improvement

The service was not always safe. Medicines were not always administered, recorded or monitored safely.

There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Risks to people who used the service were identified and managed effectively.

Staff were aware of different types of abuse, how to identify abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Good

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

People were provided with sufficient food and drink. Where people were at risk of dehydration or malnutrition, measures were in place to monitor their intake.

People were given the assistance they required to access healthcare services and maintain good health.

Staff understood the Mental Capacity Act 2005 and principles of the code of practice were being followed.

Is the service caring?

Good

The service was caring. There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding on people's background and preferences.

Is the service responsive?

Good

The service was responsive. Care plans were person centred.

People had access to a variety of activities which were imaginative and well received.

The home had a complaints policy in place; complaints were investigated and responded to. People and relatives knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider had a comprehensive system for monitoring the quality of care with regular audits and action taken where necessary. However, these audits had not identified the issues we found with medicines management during the inspection. Issues identified in another audit had not been included in the home improvement plan.

The quality of the service was monitored and an action plan was in place to address previously identified service shortfalls and improve the overall service provided.

Surveys were completed and analysed to make required improvements to the service.

There was a clear management structure in place and people and staff spoke positively of the registered manager and deputy manager.

The provider submitted required statutory notifications to CQC.

Stamford Care 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.

This inspection took place on 1, 2 and 3 February 2017. The first day of the inspection was unannounced.

This inspection was carried out by three inspectors, an inspection manager and a pharmacist specialist advisor. The inspection team was also supported by three expert's by experience who spoke to people and visitors and made observations throughout the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information that we held about the service and the providers including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had send to us following the previous inspection in September 2015. We received feedback from two placing local authorities, Healthwatch and a health professional involved with the service.

During the inspection, we obtained feedback from 30 people and 13 relatives. We spoke with the registered manager and deputy manager, the regional managing director, regional director, regional support manager, seven registered nurses including three unit leads, seven healthcare assistants, the head cook and an activities co-ordinator. We spoke with one visiting healthcare professional.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they generally felt safe living at Stamford Care Home and felt safe when supported by the care staff. Comments from people included, "I feel safe living here", "It's good. I've been here for six weeks and yes, I do feel very safe", "I feel absolutely safe, always" and "The staff are fully aware that residents need to feel safe." A relative told us, "They help with medication and are very responsive. [My relative] rang the bell by mistake and someone came immediately." However, despite this positive feedback there were some aspects of the service that were not safe.

We checked the medicines records for 18 people and we identified concerns in 17 of the records we looked at. We observed two medicines rounds and spoke to nursing staff and the home management team regarding medicines management. We also looked at audits and training records in relations to medicines management. Medicines were not being managed safely and people were being put at risk of harm. Some people were not receiving their medicines as prescribed. There were instances where people missed doses of their medicines or, in one case, received their prescribed medicine twice.

We found that some medicines were not stored and disposed of safely. A large quantity of prescribed medicines were found stored in an equipment room. The equipment room was locked, but non-clinical staff had access to the room. Medicines found in the equipment room included an anti-psychotic, an anti-depressant and a large quantity of codeine phosphate. One medicine, a medicated shampoo, was still being administered to a person despite the expiry date having passed.

People's Medicines Administration Records (MAR's) were not always in place or completed in full or accurately. Five people had allergies to some medicines, but these were not recorded on people's MAR's. Six people who had Percutaneous Endoscopic Gastrostomy (PEG's) in situ and who required medication via their PEG's did not have this recorded on their MAR charts. For another person, there was no MAR in place to record that a prescribed medicine had been administered. The application of creams was not being recorded clearly in the MARs and in line with the provider's policy. We found another instance of where there were two MAR's in place for one prescribed medicine and nursing staff were recording the morning round on one MAR and the evening round on another MAR.

One person was administered medicines covertly. This is when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. An appropriate assessment must be performed by a medical practitioner to establish whether the person lacks mental capacity. If it is determined that the person does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the service user's best interest. Paperwork was in place to document the process by with the covert medicines decision had been made with review dates. However the person was covertly administered a medicine which had not been included in the covert medicine agreement.

We found two instances of incorrect and inaccurate recording in the Controlled Drugs Register (CDR). We found the pill crusher used for the covert administration was heavily soiled with medicines residue.

We observed a medicines round and observed that nursing staff were kind and supportive in their approach with people, following good practice checking MAR charts and only signing after the administration had taken place .They were observed to check if resident's were in pain and in need of when required pain relief. We observed a nurse giving the medicines keys which included the CD key to a member of staff who did not have the authority to have the keys and potentially have access to CD's. We also observed a nurse place a dispersible medicine in a pot with two other tablets for a person. We intervened and were advised that the medicine would be dissolved at the point of administration; however the MAR for the dispersible medicine did not state that the medicine should be dissolved before administering. We could not be assured that five people had been given their medicines as prescribed.

Records confirmed that there were 16 registered nurses employed at the service. Following the inspection, we discussed medicines training with the regional support manager who advised that when nursing staff initially commence employment they complete a medicines training course after which they complete a yearly medicines competency assessment. Additional training would only then be offered if concerns were noted regarding the nurses competency. Records confirmed 13 out of the 16 registered nurses employed had recent medicines competency assessment recorded. We were informed that all nurses had completed a medicines competency assessment. However they were unable to locate the records for the remaining three nurses. The regional support manager told us that in light of the findings at the inspection, all nursing staff would undergo a full medicines training course.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that although risk assessments were in place for risks such as moving and handing and skin integrity, we found that assessments had not been carried out specific to some people's individual needs or health conditions. At this inspection we found that the provider had addressed this issue. We saw evidence that risk had been adequately assessed for people using the service. Staff were able to explain how they would work with people's identified risks.

Risk assessments were person centred, up to date and reviewed regularly. Risk assessments covered risks to people such as skin integrity, moving and handling, falls, risks associated with the use of bedrails, smoking and health conditions such as diabetes, asthma, hypertension (high blood pressure), mental health and associated behaviours.

Skin integrity was assessed using Waterlow charts to determine risk levels. During our last inspection we found that Waterlow risk assessments were not always reviewed on a regular basis for people who were assessed as high risk of developing pressure ulcers. During this inspection we found that Waterlow charts were reviewed and updated on a monthly basis and Waterlow scores had been correctly calculated. Specialist equipment was used to relieve pressure on pressure areas. Repositioning charts were in place and were up to date. We saw that the service had recently received a certificate from the local tissue viability nursing team as recognition for their proactive and responsive practice in the management of skin integrity.

At our last inspection, we found that there was insufficient staff deployed effectively to ensure people's needs were met. We found that staffing levels were not formally calculated based on people's needs. At this inspection we found that the provider had addressed this issue. The registered manager demonstrated the tool now used to calculate nursing and care staff levels. The registered manager told us that senior management were supportive of providing additional staff when required. At the time of the inspection, staffing levels were set at two nurses and five carers on each unit during the day and one nurse and two carers on each unit at night-time. Most people told us there were enough staff to meet their needs and they

received assistance when needed. Comments from people included, "[Staff] come quickly when called", "There is plenty of staff. They ask me what I want to do" and "There are staff about, usually enough." A relative told us, "[Relative] doesn't use the bell. She can't push it. I think she just waits but they do check on her regularly because she tells me"

We saw call bells were within people's reach and people told us staff responded promptly. Call bells response times were reviewed on a daily basis by the registered or deputy manager and followed up if concerns were noted. We observed that there were sufficient staff available at mealtimes to ensure people received assistance with their meals if required. We observed staff available in communal areas to assist people when needed.

Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure that only suitable staff were employed to work at the home. Records seen confirmed that staff members were entitled to work in the UK.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Records confirmed that staff had received training in safeguarding people. Staff also confirmed that they could access the safeguarding policy. They were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the Care Quality Commission.

The provider had a whistleblowing policy in place and staff were knowledgeable about what whistleblowing meant. One member of staff told us, "If you see anyone doing the wrong thing or practice I inform my manager and local authority. We have whistleblowing policy and training. I can contact my line manager and quality manager. Staff are able to whistle blow. Staff do approach manager if there are concerns or not pleased about anything."

Accidents and incidents were recorded and actions and learning identified as a result of the incident were implemented. Staff knew how to report accidents and incidents.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and gas and electrical safety were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment.

Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency.

People were protected by the use of safe infection control procedures and practices. Staff were trained and kept up to date with good practice. The home was clean and well maintained on the days we visited. Some areas of the home had recently been redecorated and on-going redecoration works were in progress when we visited. The home smelt clean and fresh at all times during the inspection.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments received from people included, "They look after us all well", "They do all they can, if you want tea they give it to you", "They [staff] come and have a chat with me and ask me what I think about things like medicines and my walking and what help I would like in the bathroom" and "They sit down with me and ask me if there is anything I would like or like to do to make things easier." A relative told us, "Yes I think they do. [My relative] isn't easy and they know him well and what he likes and needs."

At our last inspection, we found that the service was not working within the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found that the provider had addressed this issue.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS assessments to be considered for authorisation. The registered manager monitored people on DoLS and applied for reviews and renewals in a timely manner. People's care files contained a copy of their DoLS authorisation.

Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided. The staff we spoke to had a clear understanding of the principles of the MCA and how it was applied. One staff member told us when we asked about their understanding of the MCA principles, "Is the person able to retain information and make sensible decision." Another staff member told us, "[DoLS] means depriving residents of their freedom."

People and staff told us consent was obtained prior to assisting people. One person told us, "They let me do things myself and I tell them that when we have chats." Another person told us, "Yes, I am in charge of my care."

At our last inspection, we found that the service was not always ensuring people's food and fluid intake was monitored and where people refused food, we saw instances of where they were not offered an alternative. At this inspection, we found that the provider had addressed the issue.

Fluid charts had been completed for both day and night with most fluid charts totalled and signed each day, although some had not been. We discussed this with the registered and deputy manager who showed us where people's fluid intake targets, total intake and actions taken had been recorded on a separate document and reviewed by nursing staff.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. We saw evidence where a risk was identified a risk assessment was implemented in order to manage this risk. The MUST was reviewed on a regular basis and people had regular weight checks. Weight loss was recorded and referrals were made to a dietician in a timely manner. In one instance, we saw that a person had consistently lost weight and was referred to a dietician who implemented an eating plan. A nurse told us that the person had improved greatly, no longer remained in bed all day and had started to gain weight.

Referrals were also made to a Speech and Language Therapist (SALT) when concerns were noted as regards people's ability to swallow safely. Care files evidenced the outcomes and SALT instructions and we observed feeding guidelines displayed in people's rooms.

We observed mealtimes on all units throughout the inspection. A staff member told us, "We try to encourage everyone to come into the dining room to eat. Some people like to eat in their rooms and some are in rooms because they don't feel well so they will have assistance in their room." Although lunchtime was observed to be busy, the general atmosphere in the dining rooms was calm and unhurried. Menus were on display and tables were set with appropriate cutlery. No one was being rushed with their meal and staff were chatting and joking with people which was having a positive effect on their well-being. We observed many instances of kind and caring interactions between staff and people throughout mealtimes. We observed a staff member assist a person who was sitting in an electronic wheelchair. We observed that the resident was sleepy and the staff member gently chatted with him, encouraging him to eat and open his mouth. The staff member offered food on a spoon to touch the person's lip and he tasted it. The staff member asked if this was okay and the person opened his mouth. We observed this being used for each spoonful and the staff member watched the person eating and waited for him to swallow. The staff member offered the person a drink and assisted them with the cup after each mouthful of food. They gave the person lots of time and gentle encouragement during eating and the person was not rushed.

People were offered choices and support if needed. Where people refused a meal or did not eat much, an alternative was always offered. We observed that people were offered a choice of meal and care staff carried two sample meals to people so they could visualise their meal and pick. We spoke to the head cook about menu choices and we were shown the provider's menu plan as meals were centrally planned. We asked people and the head cook how people's cultural food preferences were met. We were advised that the menu was generally based on British food; however the head cook knew that some people liked cultural foods. The head cook advised us that she was preparing rice and peas and sweet potato that evening for the people she knew would like that food. A relative told us, "The food could be a bit more diverse." A second relative told us, "It seems okay and looks nice but [our relative] doesn't like it. She doesn't really like English food and we have a fridge in her room so we put Greek bits in."

People and relatives were generally positive about the standard of meals and the choices available. Comments from people included, "It's okay. Sometimes I don't fancy much and they ask if you would like something different or lighter", "It's excellent. I enjoy it", "Plenty of it and I enjoy it" and "I eat it! The broccoli is sometimes under-cooked but the soup is homemade. Yes, you get enough and you get offered seconds. I've got no complaints."

We observed throughout the inspection that drinks, such as tea, coffee and squash were regularly offered to people and when people requested a drink, they received one promptly. We observed that people who remained in their bedrooms had a drink within reach. People commented, "They ask me what I would like

and they bring it. You get a choice and I have jugs in my room that I can do" and "You can choose and I keep drinks in my room. They do check what I'm drinking because I am not meant to have too much sugar. I get that sugar free stuff."

The service had systems in place to keep track of which training staff had completed and future training needs, staff supervisions and appraisals. Staff told us that they had access to training and had received regular training. Training records confirmed that staff attended regular training which included infection control, bedside rails, challenging behaviour, dementia and cognitive issues, pressure management, risk culture and incident management, manual handling, mental capacity/DoLS, food safety and safeguarding. One staff member told us, "They give a lot of training. Dementia training was very useful." Another staff member told us, "You get training every year. It's very good. I did health and safety training. I am very careful with hoisting."

Staff told us that they received regular supervisions and appraisals and records confirmed this. We looked at staff supervision records and saw that they were themed on topics such as MCA/DoLS, food and fluid monitoring and offering people choice. We also saw that where there had been a complaint or incident involving a staff member, a supervision session took place to discuss the concerns and implement further training, if required. Supervisions and appraisals were individual to the staff member and individual objectives had been set around additional training needs.

People were supported to maintain good health and have access to healthcare services and received on-going healthcare support. Care plans detailed records of appointments with health and care professionals. We also saw evidence that following appointments, people's care plans were updated accordingly. People and relatives told us, "I ask them to call the doctor and they do. The nurse will have a look at you", "I never ask....the nurses do a good job", "The doctor is here on call weekly. [My relative] gets urinary tract infections and these are seen to in time" and "staff would phone me if anything goes wrong." We spoke with a GP visiting the service during the inspection. The GP told us that the service was responsive and requested GP intervention promptly.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and spoke positively about staff. Comments from people included, "They come and sit with me and they ask me about my family and we have a chat about things like the papers and church", "They're all very friendly and some of them know me and [named staff] does", "I'm happy here, they're very good to me" and "Yes they help me with things I find difficult like remembering things or doing my shoes." A relative told us, "Very friendly, very caring. [My relative] feels at home here".

We observed many kind and caring interactions between staff and people who used the service and their relatives when they visited. Often staff were sat chatting to people, clearly aware of people's interests or events such as recent birthdays and trips out. On one occasion, we observed a staff member enter a person's room, the person smiled at the staff member and said, "You're very kind." The staff member laughed and replied, "You are a darling as well." We also observed people being hoisted during the inspection and at all times observed staff talking to the person throughout the process. When people became agitated or upset, we saw staff intervene in a caring and patient manner. On one occasion, we observed a person become agitated. The staff member spoke in a kind and calm way to support the person to have a drink. The person gradually became more settled and the staff member was observed praising him throughout the interaction." On another occasion, we observed a staff member sitting with a person who was shouting out and using swear words. The staff member asked the person in a firm voice "[Name] please do not swear as I do not like it." We observed that the staff member was calm and addressed the person by trying to establish eye contact with them and using their name. The person continued with the same behaviours and the staff member continued to sit with the person and chat with them whilst waiting for lunch. The staff member asks the person what he would like for lunch and gave him choices and time to reply. The person chose and the staff member brought his lunch to him and ensured he was sitting appropriately and close to the table. A staff member told us, "Personally I will go out of my way for them [people]. At the end of the day, we will all be old. Sometimes they only want a cuppa and chat."

During our conversations with staff, they demonstrated they cared for the people they supported and aimed to deliver person centred care. One staff member told us, "You do things for me according to what I want and like and don't generalise. For example, use of lipstick for a resident that wants it before coming out of their room. A resident might want to wear their bangle, hair done before breakfast." Another staff member told us, "We must treat people like our mothers and fathers."

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. People were addressed by the staff using their preferred names. Staff told us they had read peoples care plans. A staff member told us, "Example of a does not want to be washed by male. She chooses what to wear and gets newspaper every day that is paid for by relative. She likes bible reading and gospel music. She communicates what she wants by writing and likes Caribbean food and salmon fish." When asked if they thought staff knew them and their needs, people commented, "Very well I think. They ask me a lot and they tell me to tell them if I change how I feel" and "They know me. They know I will tell them what I want to do and how." Most people and relatives told us they were involved in planning of their care. One person told us,

"Yes, with my social worker, occupational therapist and doctor."

Staff respected people's privacy and dignity. A staff member told us, "We saw that doors were kept closed when people were receiving personal care." When asked if they felt their privacy and dignity was respected, people commented, "They do. They really, really do", "They do. They knock on the door and they don't interrupt if I am busy with my visitors" and "Yes I feel they respect me and what I want to do. They give me independence too." A relative told us, "Yes, there are no problems. [My relative] has a bed bath, a shower and wears pads as well. All of this is done well. [My relative] prefers only women and they accommodate."

There was a key worker system in place. A key worker is a staff member who monitors the support needs and progress of a person they have been assigned to support. Reviews were undertaken regularly with people, which included important details such as people's current circumstance and if there were any issues that needed addressing. A staff member told us, "Key workers work hand in hand with relatives to meet residents care and needs. For example, if toiletries or clothes are small we inform relatives or call them to bring new or more clothes."

The provider had equality and diversity policy in place and staff had received training in this area. Staff we spoke to understood what equality and diversity meant and how that affected the care they provided for people who use the service. When asked how to work with people from a variety of backgrounds, staff told us, "We have different people from different backgrounds and treat people equally."

The home was undergoing refurbishment when we inspected and some of the dementia friendly signage had been temporarily removed. People's rooms were tastefully decorated. Rooms were personalised with family photos, ornaments and pictures. In one room we saw a mini fridge, a wall chart with translations, as well as paintings and religious references from the person's home country. Memory boxes were also on display outside people's bedrooms which had been filled with personal mementos and information about the person.

We observed a steady stream of visitors throughout our inspection. A relative told us, "Yes I'm here every day and my son is joining us at lunchtime. We are part of the home."

Care plans documented that advanced care planning and end of life care was discussed with most people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared. A family room had recently been created which provided space and privacy for relatives of people who were nearing the end of life.

Good

Is the service responsive?

Our findings

People using this service and their relatives told us that the management and staff responded to any changes in their needs. People and relatives told us and observations confirmed that pain relief was offered to people. A relative told us, "Staff are very observant. For example they notice when [my relative] is in pain and offer him a pain killer".

We saw from people's care records and by talking with staff that if any changes to people's health were noted by staff, they would report these changes and concerns. Relatives told us they were kept up to date with any issues and involved in care reviews. A relative told us, "I take part in care planning." A second relative told us, "I am consulted when decisions are made." A third relative told us, "Very involved. They chat to me and the family and we all chip in and they seem to listen. They do feedback and tell us about changes or how [my relative] is doing today and what kind of night she has had."

People's individual care plans included information about life history, cultural and religious heritage, daily activities and communication. Care plans were reviewed regularly and updated as changes occurred. Through our observations and discussions with staff they demonstrated an awareness of people's preferences, what people were able to do and what they needed support with. Records showed pre-admission information had been completed. An assessment was carried out to identify people's support needs and they included information about their medical conditions, behaviour, communication and their daily lives. A staff member told us, "Assess residents when admitted and ensure care plan is done differently and personalised.

People were supported to engage in activities on a daily basis. Notices about activities and events were displayed around the home. We observed dedicated activities co-ordinators deliver the programme. On the days of the inspection, activities included bingo and exercise, in addition to music therapy and a comedian sourced externally. On one day of the inspection, a bible reading session took place. One person told us, "I can have holy communion if I need or want it."

We could see that people and relatives enjoyed the activities on offer and people benefited from the stimulation. We completed an observation exercise on a morning of the inspection and saw that the activities co-ordinator worked very hard to engage with the people with dementia. Interactions were friendly and appropriate. People gradually 'work up' and showed signed of well-being such as laughing and smiling. The activity worker maintained this engagement throughout the exercise session. When asked about activities, people told us, "They make a huge effort to keep people occupied", "I like going out and go to the shops with them. I like the garden and we had a BBQ which was good. I like TV in my room and watching films. I do a lot and they ask me to join in if I want to", "I like reading the paper and my bible sometimes and I like playing cards and colouring. I like music. We have all of that stuff" and "There is plenty to do. Singing is best. I am going to have a nice birthday party in February." A relative told us, "Yes there are a lot of activities here. I help [my relative] with the bingo." The activities co-ordinators regularly updated people's care plans with details of the activities they took part in and their enjoyment of the activity.

People could choose if they wanted to stay in their bedrooms or go to the communal areas. A person told us that they preferred to be in their room with the door open. The person had a large collage of photographs put together by the people who own and run the cafe they used to go to regularly. The person told us, "I like the outings...to the park." Other people told us, ""I can choose but I like to be in there as I have all my things I need to do" and "I like the lounge so I can have a chat with staff and other people."

We checked how the service handled complaints. We saw that any complaints received had been investigated fully and appropriately, in line with the home's policies and procedures. Responses from senior management were open and detailed. Where mistakes had been made these were acknowledged and apologies provided. People and relatives generally told us that they had no complaints and any concerns raised were appropriately dealt with. People and relatives told us that they felt free to raise concerns in confidence. A relative commented, "The manager. They have an open door thing. They tell you to come in or call anytime." Another relative told us, "[My family and I] feel free to raise things and they get sorted. There were problems here before." The relative also told us that following a suggestion to the registered manager, a change was implemented which greatly improved the dining experience of people who used the service.

There were complimentary cards from relatives thanking staff for looking after their family members. Compliments from one relative included "Staff were jolly, always helpful. We couldn't ask for a better place."

There were arrangements in place for people and relatives to provide feedback. A resident's experience survey was sent to people on a twice-yearly basis and the results were collected and analysed. The most recent results had been collated in December 2016. 16 people completed the survey and feedback was overall positive with 80 per cent of respondents saying they were happy and content, 88 per cent felt safe and secure and 100 per cent said they were treated as individuals. The results were discussed at residents meetings and where feedback indicated an area which required improvement, an individual survey was also sent to people to ascertain further information.

Requires Improvement

Is the service well-led?

Our findings

Overall, people and relatives were positive about the service they received and told us they thought the service was well managed. A person commented, "I know the manager on this floor. I would recommend this home." Another person told us, "It's a lovely place and the care is excellent." We received a mixed response when we asked people if they knew the registered manager, with some people telling us they did not know the registered manager but knew the manager on their floor. People and relatives were confident that they could raise concerns and contact staff when needed. Relatives commented, "I have not met the manager. If I met him I would tell him what a good place he is managing", "The service is well managed and perfect for my husband" and "The new registered manager has made some positive changes."

We observed an open culture and welcoming atmosphere at Stamford Care Home. Staff felt management within the home and the registered manager and deputy manager were open, honest and approachable. They felt listened to and were able to raise any concerns they had without hesitation. When we discussed people's needs with the registered manager and deputy manager they knew details about everybody living at the home and about staff and their needs. We observed the registered manager and deputy manager, as registered nurses; assist with clinical duties such as dressing changes and obtaining blood samples. Comments from staff included, "[Registered manager] is very hardworking and very good", "Very good. No fighting, bullying and harassment. If there is an incident we inform manager, complete forms and write statement", "[Registered manager] is very nice. We work as a team. He respects us" and "Very good. Very visible manager. He knows what he is doing."

There were systems in place to monitor the safety and quality of the service provided. These included quality surveys, monitoring of call bell response times, mystery shopper, unannounced night spot checks, daily and weekly clinical meetings and quarterly audits of the service by the registered manager. The registered manager also carried out a first impressions audit which involved assessing the outside the home, foyer/reception area, people using the service, home environment, kitchen and dining experience and bedrooms/bathrooms. At an audit completed on 1 December 2016, the findings included; untidy appearance in areas, equipment not stored appropriately, menu not up to date and unappetising food, come negative feedback from people regarding activities on offer and maintenance and tidiness issues in some bedrooms. The audit stated that actions would be included in the home improvement plan. However the home improvement plan updated on 20 January 2017 did not include the findings of the first impressions audit.

The registered manager was required to submit monthly reports to their line manager. This ensured the provider was aware of how the service was doing. The report included accidents and incidents, home acquired pressure ulcers, significant weight loss, mortality rates, medicines errors, hospital admissions, safeguarding's and DoLS, infections, manager care plan reviews and complaints. The events were analysed and investigated to ensure that lessons were learnt, acted upon and that risks were reduced or eliminated where possible. However, despite the comprehensive systems in place to ensure people received quality and safe care, the quality assurance measures in place did not identify the significant concerns with medicines management which were raised during the inspection.

The visions and values of the service were shared by the whole staff team and staff told us they were proud to work at the home. A staff member told us, "I live local and when I first came here (to work here) people complained about BUPA on thing like residents were losing weight. However, now people give good compliments and family are happy, which I am proud of." Another staff member told us, "Our values are taking care of people, meeting people needs, choices, safe and comfortable."

At our last inspection, we found that the provider had not notified us of the outcomes of DoLS applications. At this inspection we found that the provider had addressed this issue. This meant that the provider had told us about significant events affecting people's care and support needs. The most recent CQC inspection rating was on display throughout the home.

The service had a home improvement plan in place. Findings from previous CQC inspections and local authority feedback formed the basis of the home improvement plan. The home improvement plan was updated when actions had been completed and examples of recently completed improvement actions, which were evidenced on inspection, included updating care plans with DoLS outcomes, implementation of a staffing dependency tool and review complaints management.

People and relatives told us they attended meetings where they could raise concerns. Minutes from a recent meeting outlined that some people did not attend as they did not want to miss the weekly music therapy session. The home improvement plan was discussed, feedback from people and relatives was received which included consideration for a more ethnically diverse menu. This was reiterated in feedback received by the inspection team by some relatives and staff.

Staff feedback was obtained through a staff survey and staff meetings. The most recent staff survey was undertaken in October 2016. Feedback from staff was mostly positive in relation to the home working environment. Staff told us that improvements had been made as a result of a staff survey. A staff member commented, "We are informed of outcomes, for example, here we discussed increment of the minimum wages, food spicy for Afro-Caribbean [people]. The home now does jollof rice which is an improvement as a result of the staff survey. Also we used to be given one uniform which fades away after three months, now five uniforms are given to staff." Another staff member told us, "We moved things around in the lounge so residents could see the telly better."

Staff meetings took place on a regular basis which included daily clinical meetings and regular unit meetings. Staff told us that meetings were beneficial and that they could contribute to meetings and raise concerns. Staff commented, "You can talk openly", "We talk about the job" and "Unit meetings are done monthly on each floor. All units have a team meeting every 3 months. Departmental heads also meet I think every week."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(g) The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines.

The enforcement action we took:

We issued a warning notice on the registered provider and registered manager on 14 February 2017.