Stonehaven (Healthcare) Ltd

St Petroc's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: St Petroc's is a residential care home in Bodmin that provides personal care for up to 30 older people, some of whom are living with dementia. 23 people lived at the service when we visited.

People's experience of using this service:
We identified several safety risks identified in relation to the environment. People were at increased risk of scalds because hot water temperatures in wash hand basins in bathroom, shower and numerous bedroom areas were too hot. One fire exit was poorly maintained and another wasn't properly sealed which meant it would not prevent the spread of a fire. Other safety risks included uncovered electric portable radiators, which were hot to touch, and a pressure relieving mattress which wasn't working properly. An unmarked change of floor level was a slip, trip, fall hazard for people.

We brought these risks to the attention of the registered manager. Since the inspection, they have contacted us to confirm work undertaken to further reduce the risks.

Other parts of the environment and equipment were well maintained. People had detailed personalised risks assessments which showed ways staff reduced individual risks for people, such as falls risks.

People said they felt safe living at the home, and further work was underway to improve security. There were enough staff to keep people safe and meet their needs. People were protected because staff knew about signs of abuse and felt confident to report concerns. People received their medicines safely and on time. People were protected from cross infection by good hygiene measures.

We observed caring interactions between people and staff around the home. However, on the first day of the inspection, people had a very poor dining experience. They waited a long time for their meal and people who needed assistance were not appropriately supported. We fed back our observations of people's lunchtime experience to the registered manager, who spoke with staff and made sure people's dining experience the next day was improved. Since the inspection, the registered manager has promoted improved staff practice through regular mealtime observation.

The service was an old Victorian building. Some adaptations in bathroom/toilet areas had been made to meet people's needs but further improvements in disabled access were needed. For example, some toilets areas were not easily accessible. The registered manager explained refurbishment was currently on hold as the provider was looking at the feasibility of a major extension to create additional rooms. Some improvements in the environment and equipment had been made. The lounge had recently been redecorated. Electric profile beds had been purchased which were easier for people to get in and out of, and minimised moving and handling risks for staff.

Most people said staff treated them with dignity and respect and people looked well cared for. Families could visit anytime and were made welcome. Several people participated in their local community. People

and relatives said staff consulted them in decision making, although their involvement was not always well documented.

People said they didn't always do enough to occupy them and we identified meaningful activities as an area for improvement. People's care records included personalised details about their life history, preferences and communication needs. Most people's care plans were detailed about their individual needs and preferences, with one exception, which we made the registered manager aware of.

People were supported to have a comfortable, dignified and pain-free death. Where people had expressed any advanced decisions about resuscitation, this was recorded in their care plan. However, records of people's wishes for their end of life care and any preferred funeral arrangements needed improvement.

People knew how to raise concerns and complaints and any concerns were positively responded to with improvements made in response. However, the complaint log had limited detail about the nature of more minor complaints which meant it was difficult to identify any themes or trends.

The service had quality monitoring systems in place. However, these needed to be improved, as they were not fully effective in identifying and addressing health and safety, dignity and other care issues for people. People's feedback about leadership at the service was mostly positive. Local health and social care professionals said staff worked in partnership with them.

People were asked for their consent before they received any care and treatment and staff acted in accordance with their wishes. Since the last inspection improvements in recording best interest decisions had been made for people who lacked capacity.

People received care from staff who received training and support to enable them to meet people's care and treatment needs. People's individual health needs were assessed. Care records showed staff followed evidence based practice. Health professionals said staff contacted them appropriately and followed their advice.

Rating at last inspection: Good. (last report published 15 August 2016)

Why we inspected: This was a planned inspection based on the rating at the last inspection. Some areas of the service had deteriorated and it the service was rated Requires Improvement overall. We have made requirements about two breaches of regulations found at the service.

Follow up: We will revisit the service in the future to check if improvements have been made. We will continue to monitor intelligence we receive about the service until we return to visit. If any concerning information is received we may inspect sooner.

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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led

Details are in our Well led findings below.

St Petroc's Care Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: Two inspectors 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 for older people. Our expert by experience was a wheelchair user and had a visual impairment, so also had personal experience in those areas.

Service and service type: St Petroc's is a care home. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced. Inspection site visit activity started on 13 November and finished on 14 November 2018.

What we did: The provider sent us a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the home, such as details about incidents the provider must notify CQC about, for example abuse.

During the inspection: We spoke with 12 people and three relatives to ask about their experience of the care provided. We looked at ten people's care records and at five people's medicine records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the deputy manager and with nine other staff who included care, catering and housekeeping staff. We looked at five staff files around staff recruitment, supervision and appraisal and at staff training records. We also looked at quality monitoring records relating to the management of the home such as audits and quality assurance reports. We sought feedback from commissioners, and health and social care professionals who worked with staff at the home and received a response from four of them.

Following the inspection, the registered manager sent us additional information to show what further action they had taken to reduce immediate risks for people. For example, in relation to scald risks, fire safety and other health and safety concerns.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We identified several safety risks in relation to the environment. People were at increased risk of scalds because hot water temperatures in one shower and numerous wash hand basins in bathroom and bedroom areas were too hot. The provider confirmed thermostatically controlled valves were fitted to all baths and showers, which should control water temperatures within safe recommended limits. Where staff supported people to bathe or shower, staff said they checked water temperatures were within safe limits, although there were no records of checks to confirm this.

● The provider's own checks had identified the hot water in wash hand basins exceeded Health and Safety Executive recommended maximum limits for vulnerable people. They planned to start work on 14 December 2018 to fit thermostatically controlled valves to all the taps used by people. Meanwhile, sufficient steps had not been taken to reduce risks of scalds, particularly where people were accessing hot water taps independently. Although 'caution hot water signs' were displayed in some areas, in others they were not, so people were not always warned of the risks or have cognitive ability to understand those risks due to their dementia.

● Some fire safety risks were also identified. These included a poorly maintained fire exit, via slippery steps, with a rotten broken fence rail with the escape route obstructed by debris. A recent fire risk assessment had identified an ill-fitting fire door. Although a contractor had completed remedial work on this door, there were still gaps around the edge. This meant it would not be effective in preventing the spread of a fire or smoke. The registered manager was in process of trying to resolve this issue with the contractor and the fire risk assessor, to ensure it met legal requirements.

● There were several uncovered electric portable radiators in use around the home, which were hot to touch but were not covered. This could increase risk of burns. Other environmental risks included an unmarked change of floor level, disguised by a carpet which sloped towards a steep set of steps. This caused a near miss incident by our expert by experience. The unmarked varied floor levels were a slip, trip and fall hazard for other people.

● A person who was cared for in bed, said, "My mattress is very uncomfortable, I would like a new one." On further investigation, we found their pressure relieving mattress was not working properly as it had some deflated cells. This also placed the person was at increased risk of pressure damage.

● People were at increased risk as security at the main entrance of the home was lax. Inspectors and the expert by experience, who arrived separately, both accessed the home unchallenged. This was although we rang the bell, and staff saw us arrive. A health professional also commented on the lack of security letting visitors into the home.

These risks were a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

● We asked the registered manager to take further immediate steps to address each of these issues, which

they started to do during the inspection. On 21 November 2018, they sent us details of additional steps being taken to improve safety.
● Work to fit thermostatically controlled valves on taps was brought forward and commenced on 15 November with highest risk areas completed as a priority. Meanwhile, staff assisted people at risk when using hot water, and additional hazard signage was obtained.
● Remedial work was carried out to bring the poorly maintained fire safety exit up to standard. The provider arranged for a fire safety expert to visit the home and advise further on the remaining fire safety concerns.
● Individual risk assessments were carried out on the use of portable radiators in people's rooms, with additional steps taken to minimise risks.
● The provider arranged to visit to identify what further steps were needed to make the change of floor level slip/trip/fall risk safer. Meanwhile, the area had been clearly marked with hazard signage.
● A person's faulty pressure relieving mattress was replaced.
● The registered manager confirmed the provider planned to install a key pad entry system to the main front door. This was in response to people's suggestions during a residents meeting in October 2018 about how best to improve security at the main entrance.

● Other parts of the environment and equipment were well maintained. Where other slip, trip and falls risks had been identified, these had been addressed. For example, by fitting a keypad to stop people accessing a steep staircase without assistance. A maintenance member of staff visited three days a week, to undertake repairs and ongoing maintenance. Electrical and gas appliances were regularly serviced and tested, as was equipment such as beds, hoists and slings. Weekly fire alarm tests were carried out and each person had a personalised emergency evacuation plans about the support they needed to evacuate in the event of a fire.
● Staff understood what support people required to reduce the risk of avoidable harm. Personalised risk assessments described measures to reduce risks as much as possible. For example, staff undertook regular monitoring checks throughout the day and night for people at high risk of falling and those who were cared for in bed.

Staffing levels
●There were enough staff on duty to keep people safe and meet their needs. People's comments on staffing included; "They [staff] pop in quite often," "They come quite quickly when you need someone."
● The service was fully staffed. Each morning there were five care staff on duty, including a senior or deputy manager, with staffing levels reducing to three care staff in the afternoon. Each day there was a cook, with a housekeeping and member of staff in the laundry five days a week. Since the last inspection, night staffing levels had increased from one to two waking staff on night duty. The registered manager worked five days a week and also worked on the floor when needed.
● They registered manager used a dependency tool to guide staffing levels. This was reviewed regularly as people's individual needs changed.
● Although some people were rushed at lunchtime, we thought this was related to shift finish times as one staff member went off duty at 1230 and another at 1330. This didn't meet people's increased needs at that time of the day, which the registered manager said they would review.
● Staff confirmed staffing levels enabled them to keep people safe and meet their needs. Any additional hours needed were provided by existing staff working extra hours, or by using agency staff.
● Staff had been recruited safely. All required pre-employment checks had been carried out including reference checks from previous employers.

Safeguarding systems and processes
● People said they felt safe living at the home. Their comments included: "I feel safe with the staff here," "I think it is safe here and I feel fine," and "I would talk to a carer if I was worried." Relatives said; "Mum loves

the staff here and she can talk to them if I am not around," and "I've no concerns, if I had, I would report to a senior and I think they would take action."
● People were protected from potential abuse and avoidable harm by staff who had regular safeguarding training and knew about the different types of abuse.
● The provider had effective safeguarding systems in place and all staff had a good understanding of what to do to make sure people were protected from harm or abuse. No safeguarding concerns had been identified or reported to the Care Quality Commission since the last inspection.

Using medicines safely.
● People received their medicines safely and on time. Staff were trained in medicines management and had regular competency checks to ensure safe practice.
● People were happy with the support they received to take their medicines. People's comments included; "I always get my medication on time," "They ask if I am in pain and give me pain medication if needed."
● Each person's prescribed medicines were reviewed by their GP regularly. A recent pharmacy audit in November 2018 had not identified any significant concerns.
● Some people had been prescribed medicine to be used as required (PRN). Some people had protocols in place to guide staff about their use, but others did not. By the second day of the inspection, the deputy manager had addressed this.
● People's medicines were safely received, stored and administered. Medicines were audited regularly with action taken to make ongoing improvements, such as reminding staff to sign and date newly opened creams.

Learning lessons when things go wrong
● Accidents and incidents were reported and monitored by the registered manager to identify any trends. For example, monthly reviews of accident reports showed three people were at higher risk of falls, so staff knew to check on those people more regularly and offer them additional support.
● The registered manager discussed accidents/incidents with staff as a learning opportunity. For example, where an ordering error occurred, which delayed a person getting their prescribed medicine.

Preventing and controlling infection
● People were protected from cross infection. The service was clean and odour free. One person said, "Yes the home is very clean, the cleaners work hard here."
● Staff had completed infection control training and followed infection control practices. They used protective clothing gloves and aprons during personal care to help prevent the spread of healthcare related infections.
● A Food Standards Agency inspection in December 2017 awarded the service the highest rating of five out of five.

Requires Improvement

Is the service effective?

Our findings

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough with choice in a balanced diet

● On the first day of the inspection, people in the dining room had a very poor dining experience. Some people sat waiting at the table for at least 30 minutes before lunch was served. There was no menu in the dining room to remind people what was for lunch. The portions served were large, which some people found unappetising. One person struggled to chew the meat and said the vegetables were hard, so they gave up and had their dessert. When a person asked for more gravy, it was served in a bowl which was difficult for them to pour.

● A person on a pureed diet, had all pureed components of their meal mixed together in an unappetising way, which is poor practice. A staff member assisted three people to eat simultaneously. They started spooning food into one person's mouth with no conversation. After two spoons they left the person, and helped two other people to cut their food and then returned to the first person. After lunch, another member of staff made people hot drinks, without asking people what they would like to drink or whether they took milk and sugar.

● We fed back our observations of people's lunchtime experience to the registered manager, who spoke with staff and supervised people's dining experience the next day to make sure it improved.

● On the second day staff offered people choices. There was background music playing and the atmosphere was more relaxed and unhurried. A staff member explained in detail to a visually impaired person what food was on their plate.

● Since the inspection, the registered manager told us she was promoting improved staff practice through regular mealtime observation.

● People's feedback about food was mixed. People's comments included: "The food is alright, some days better than others," "The food was excellent but the cook has left and the carers are doing it and it is not very good now." One of the two chefs had recently left the service, a replacement chef had been appointed and was due to start the following week.

● There was a four- week menu cycle, with one main meal choice and alternatives such as a jacket potato or an omelette available. The registered manager said they were working towards offering people two main meal choices and were offering people more fresh fruit and vegetables.

● Kitchen staff were aware of people's individual food preferences, allergies and dietary requirements. People were offered regular drinks and people in their rooms had drinks within their reach. Records of eating and drinking were kept and action taken where there were any concerns about people at risk of malnutrition or dehydration.

Adapting service, design, decoration to meet people's needs

● The service was an old Victorian building. Some adaptations in bathroom/toilet areas had been made to meet people's needs but further improvements in disabled access were needed. For example, some toilets were not easily accessible by people using a wheelchair or walking frame due to the restricted space. The nearest toilet for a person with a walking frame was down a long corridor, which was a struggle for them. A

relative said, "My mum has to use a wheelchair and her room is in the annexe. We would prefer her to move into the main home as she finds the continual transferring from wheelchair to stairlift up to seven or more times a day exhausting due to her medical condition."

● At the main entrance, there was a temporary wheelchair ramp, but there were no other ramps, including at fire exits. The service had no dedicated equipment store which meant wheelchairs, hoists and other equipment was stored in bathroom and corridor areas. This made these areas less accessible to people and meant staff had to move equipment out each time a person wanted to use the bathroom. A staff member said, "It's a nuisance having to move all equipment out of the bathroom and shower room to use them."

● The registered manager explained plans to refurbish the main bathroom downstairs were currently on hold. This was because the provider was looking at the feasibility of a major extension to create additional rooms. ● Upstairs, there was a recently decorated lounge, with new furniture, a library and a TV. People liked to use this room to read quietly, entertain visitors or watch sport programmes. Some bedrooms had drawers and wardrobes specially purchased for use by people living with dementia. For example, they had transparent panels, so the person could see what was inside. In August 2018, the service purchased 21 electric profile beds which were easier for people to get in and out of, and minimised moving and handling risks for staff.

Ensuring consent to care and treatment in line with law and guidance

● People were asked for their consent before they received any care and treatment and staff acted in accordance with their wishes. For example, before assisting a person with personal care and getting dressed. One person said, "Yes I can choose what time I want to go to bed if I wish." A staff member said, "I always give them a choice, [person] can choose what they want to wear, or if they want a shower."

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● Since the last inspection, improvements had been made in recording best interest decisions for people who lacked capacity to make the decisions for themselves. Care records described how a person's legal representatives, relatives and professionals were consulted and involved in a best interest decision. For example, to use a pressure mat to alert staff when a person left their bedroom. This was so staff could escort the person downstairs for their safety.

● 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 who lacked capacity were subject to some restrictions for their safety, the registered manager had submitted DoLS applications to the local authority DoLS team, two of which had been authorised.

● We checked whether the service was working within the principles of the MCA and if conditions to deprive a person of their liberty were being met and found staff they were. For example, a person's care records showed the action staff would take if a person tried to leave the building unaccompanied.

Staff skills, knowledge and experience

● Staff received training and support to enable them to meet people's care and treatment needs. Most staff had qualifications in care. New staff completed an induction which included working with more experienced staff. A member of staff said, "It was good shadowing to get to know the clients and their routines." Where staff were new to care, they completed the Care Certificate, a set of national standards social care workers are expected to adhere to.

● Training methods included online, face to face training and competency assessments. Staff said training was good, one staff said, "We do loads of training, I'm doing dementia training and will be doing my level

three diploma." Staff felt well supported through regular supervision, and had an annual appraisal to discuss their further development needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's individual health needs were assessed. Care records showed staff followed evidence based practice in relation to moving and handling, nutrition, pressure area care and for people with diabetes.
● For example, where there were concerns about a person's weight, they were weighed more frequently and professional advice followed about offering the person smoothies or other food supplements.

Supporting people to live healthier lives, access healthcare services and support; Staff provided consistent, effective, timely care within and across organisations
● People had access to a variety of healthcare services and professionals according to their specific needs. One person said, "They will call the doctor if I am unwell," another person said the community dentist had visited them. A relative said, "Mum is quite happy here and seems to be well looked after. Staff respond quickly when she's unwell and keep me informed." A health professional said, "We visit the service most days, and staff let us know if they have any concerns."
● A specialist nurse visited a person with Parkinson's (a neurological condition), and a diabetes nurse visited people with diabetes. They discussed problems those people experienced with staff and provided them with advice on the management of the conditions. These discussions helped staff widen their knowledge, which made a difference to those people. For example, by encouraging people to make simple changes to eating habits which helped to improve their health.
● The home was participating in a new emergency care service based at a local GP practice. A paramedic telephoned the home each day to see if the home was worried about anyone, and if so, called to see them. The aim of this was to identify changes in people's health earlier and treat them, for example, spotting early signs of a urine infection.

Requires Improvement

Is the service caring?

Our findings

People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● At lunchtime in the dining room, on the first day of the inspection, people's dignity and independence was not well promoted or supported. For example, a person with a visual impairment was given a fork to eat their lunch but staff did not explain to them what was on their plate. Every so often, the person called out and said "Hello" repeatedly, but care staff nearby did not respond or seem to notice they struggled to eat their meal. Eventually the deputy manager came into the room and spoke with the person, and a visiting professional helped them eat their meal.

● After lunch we observed another person being moved out of the dining room in their wheelchair, without being asked. The staff member placed the person's feet on the footplate, pulled the wheelchair backwards without warning them and pushed the person into the corridor without speaking with them.

● People looked well cared for and most people said staff treated them with dignity and respect. People's comments included; "They are respectful and always knock the door before coming into my room." "They do try to ensure my privacy when bathing me." Care records showed what aspects of care people could manage themselves and what they needed staff help with. Toilet and bathroom doors were identified with symbol signage, which helped people to identify them independently. To assist a person to mobilise, staff were instructed to keep the person's stick by their bed to encourage them use it.

● Families could visit anytime and were made welcome. A relative said, "The carers always make us welcome." Several people participated in their local community. People's comments included; "My friends take to me church where I love to sing. I also go out for meals with my friends, "My daughter takes me out to the memory café where we have a sing a long which I enjoy a lot." A person who was nursed in bed appreciated being able to receive communion regularly.

Ensuring people are well treated and supported

● Most people gave positive feedback about staff. People's comments included; "Staff listen to me and will help me deal with things," "Staff are very nice and they help me, although a couple of others are not so caring." We observed caring interactions between people and staff around the home. Staff spent time with people, they did not rush them. One person appreciated that a member of staff brought a book in for them to read. When another person couldn't remember what day it was, a member of staff gently reminded them.

● People's room were personalised with things that were meaningful to them such as family photographs, favourite soft toys and pictures. One person had lots of railway stuff memorabilia.

Supporting people to express their views and be involved in making decisions about their care

● People were involved in day to day decisions such as what time they got up and went to bed, and about how they spent their day. A person was asked if they wanted a wash and what clothes they would like to wear. Where people were in their rooms they said this was their choice.

● People and relatives said staff involved them when people need help and support with decision making. However, people's involvement in decisions about their care and treatment and in reviews of their care plans was not well documented. One person said, "I know I have one [a care plan] but I have never asked to

see it or been shown it," and another person said, "I have no idea if there is one on me."

Requires Improvement

Is the service responsive?

Our findings

People's needs were not always met.

● People said they didn't always have enough to occupy them and we identified meaningful activities as an area for improvement. People's comments included, "Although we have a list of activities they rarely happen. A lot depends on who is on duty," "I like singing but it doesn't happen very often. I get really bored at times." A relative said, "Carers here don't always get the time to interact with residents." A staff member said, "There could be more for the residents to do."

● The service did not have an activities co-ordinator. The registered manager explained a member of staff had dedicated time each afternoon for organised activities, although this wasn't clear on the rota.

● An activity board showed planned activities included bingo, music and movement, memory ball, book reading, and a quiz. External entertainment was also arranged, for example, visiting animals, singing and a magician. On the first day we visited, card games were planned but these didn't happen. On the second day, staff did a bingo activity which people enjoyed and a member of care staff painting a person's nails. Another member of staff looked at photo albums of South Africa with a person, and chatted with them about the time they had spent there.

● On the second floor there was a library with an stock of books for people to borrow. A monthly newsletter provided items of interest to people, for example, an article about post boxes, and the history of baked beans. The home had shared use of a minibus owned by the provider, which meant group outings could be organised every few months.

● The registered manager was in the process of trying to arrange a monthly coffee morning to increase community involvement in the home. They were also planning a Christmas fair. One person was knitting scarves in preparation, with other entertainment planned.

● Most people's care plans were detailed about their individual needs and preferences, with one exception. The care plan of a person with mental health issues didn't adequately cover the risks and challenges staff described when caring for this person. Mental health professionals were reviewing this person's needs, to give staff advice about how best to care for them.

● People's care records included personalised details about their life history and preferences. For example, that a person used to work in a shop, liked to get up early and enjoyed watching soaps and gardening programmes. The person's care records said, "I like visits from staff, so I don't feel isolated." My morale can drop, talk about cats and my husband can lift my spirits. To meet my needs, I find reminiscing helpful."

● We looked at how the provider complied with the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they are given.

● Each person's care plans included a section about their individual communication needs. For example, about any visual problems or hearing loss and instructions for staff about how to help people communicate effectively. For a person with hearing loss, their care plan said, "Hearing aids to be worn through the day. When talking to [person's name] maintain eye contact, talk in a clear voice, speak slowly." Where other people with a hearing loss chose not to wear their hearing aid, staff often wrote messages to them. For a person with a visual impairment staff used red paper when playing bingo which help them see as much as possible.

End of life care and support

● People were supported to have a comfortable, dignified and pain-free death. Two people receiving end of life care died the day before our visit, so staff were still upset about their loss. A community nurse praised end of life care at the home.

● Where people had expressed any advanced decisions about resuscitation, were recorded in their care plan. However, only one of ten care records we looked at captured records of people's wishes for their end of life care and any preferred funeral arrangements.

Improving care quality in response to complaints or concerns

● People's concerns and complaints were listened and responded to. People said staff listened to them and resolved any day to day concerns. People's comments included; "You can talk to them at any time" and "If I have anything to complain about I would do so to the highest person I could to ensure it is dealt with to my satisfaction."

● The provider had a complaints policy and procedure. Written information about how to raise a complaint was in each person's room and was available in an accessible format for them.

● Care staff dealt with any verbal complaints. However, the complaint log had limited detail about the nature of more minor complaints which meant it was difficult to identify any themes or trends.

● We followed up a formal complaint CQC had been made aware of. The complaint records showed the concerns raised were investigated. A face to face meeting with relatives was arranged to resolve differences and agree a way forward. In response to concerns raised about the laundry service, a dedicated laundry assistant had been employed five days a week with improved arrangements for managing each person's laundry. This showed complaints were taken seriously and used to identify further improvements.

Requires Improvement

Is the service well-led?

Our findings

Service management and leadership was inconsistent. Leaders, and the culture they created, did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

- The service had a range of quality monitoring systems. These included audits, daily, weekly and monthly checks and a monthly monitoring visit by the provider or their representative. However these quality assurance systems were not fully robust as they had not identified or addressed a number of issues. For example, checks had failed to identify some health and safety risks and had failed to take sufficient action to mitigate other known risks.
- An inaccurate risk assessment completed by registered manager on 23 May 2017 said people's risk of scalding was minimised because thermostatic valves had been fitted, whereas they had not been. Although regular documented fire safety checks were carried out, the provider had not identified or taken any action to address a poorly maintained fire exit. A person's pressure relieving mattress wasn't working properly, which highlighted staff didn't undertake any checks to ensure this equipment was working effectively.

The lack of robust and effective quality and safety monitoring systems were a breach of regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

- Following the inspection, the registered manager sent us additional information which demonstrated additional action had been taken to reduce immediate risks for people. They also sent us an improvement plan which showed ongoing steps to further improve people's safety and make care more personalised.
- Quality monitoring feedback showed improvements had been made in response to findings from audits and other checks. For example, to make safety improvements in the car park and follow up a member of staff overdue for some training.
- People's feedback about leadership at the service was mostly positive. People's comments included; "I know the manager and can talk to her. She comes into my room and talks to me and she is very nice," "Most of the carers are amazing."
- The registered manager had notified the Care Quality Commission (CQC) about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider had displayed their previous inspection report in the home, and on their website in accordance with the regulations.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- Staff gave us positive feedback about leadership at the home. A staff member said, "The registered manager is nice, friendly, and I feel able to raise concerns." Other staff described "A good atmosphere" amongst the staff team. Health professionals said they had built a good rapport with the registered manager and their deputy.
- The registered manager did at least two planned shifts working alongside staff each month, and spent

time observing their practice. They said they were working with staff to change the culture to be more person focused and less task focused. This was through role modelling, individual staff supervision and through discussions at staff meetings. The registered manager was training senior staff to be fire wardens, so they could take on those responsibilities.

● Day to day, the deputy manager led the care team, and had a lead role in medicines management. Senior care staff updated and reviewed people's care plans, which the deputy manager checked. At the time of inspection, they were working with staff to make people's daily records more person centred.

● Accidents and incidents were reported and monitored by the registered manager to identify any trends. They discussed accidents/incidents with staff as a learning opportunity. At daily handover and staff meetings they discussed with staff how best to support individuals, and reviewed any incidents, accidents or safeguarding concerns.

Engaging and involving people using the service, the public and staff

● People were consulted and involved in day to day decisions about the running of the home and through regular meetings.

● The service carried out an annual survey. The most recent survey completed in February 2018 showed people and relatives were happy with the service and would recommend it to others. One relative wrote, "Genuinely warm and friendly staff, always patient and thoughtful towards residents and visitors alike."

● People and relatives were also encouraged to give feedback on the Care homes website, which showed scores of 9.5 out of 10 from 24 reviews. Feedback comments included; "Very helpful concerned staff," "Although dad was only there for a month he improved so much due to the care."

● Staff were consulted and involved in decision making at the home and regular staff meetings were held. Minutes showed people's individual care needs were discussed, with staff encouraged to raise areas of concern.

● Only four staff responded to the staff survey and said they were "somewhat satisfied" working for the service. The February 2018 survey highlighted retention of staff and listening more to staff views as areas for improvement.

● A bimonthly 'Mystery Shopper' audit was carried out by a person who posed as a relative looking for a care home for their relative. Results for the last two visits were positive.

Working in partnership with others; Continuous learning and improving care

● The service was continuously learning and improving through training. Staff worked in partnership working with health and social care professionals such as district nurses, the community mental health team, occupational therapists and physiotherapists. For example, a person nursed in bed, had recently been able to sit their chair for first time, after community nurses came to review their moving and handling equipment.

● The registered manager attended a bi-monthly meeting for registered managers and met up regularly with other registered managers within the Stonehaven group. This meant they shared ideas and best practice ways of working. They also kept up to date with regulatory changes through monthly newsletters from Care Quality Commission.

● Further improvements planned for 2019 included extending the patio at the back of the building to create a useable area for people to sit and enjoy the garden. This will include seating areas and raised planters to enable people to do gardening.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at increased risk of avoidable harm. This was because insufficient actions were taken to minimise risks related to excessively hot water, fire safety and other health and safety hazards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems had not sufficiently monitored and mitigated risks relating to health, welfare and safety of people using the service.