Stoke House Care Home Ltd

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Inspection report

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Date of inspection visit: 26 November 2015
Date of publication: 22/01/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 26 November 2015. Stoke House Care Home provides accommodation for up to a maximum of 46 older people who require accommodation with nursing or personal care. On the day of our inspection 22 people were using the service.

We carried out an unannounced comprehensive inspection of this service on 27 and 28 July 2015 and 7 August 2015. Breaches of legal requirements were found. We issued three warning notices in relation to three of these breaches.

We undertook this focused inspection to confirm that the provider had met the requirements of the warning notices. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stoke House Care Home on our website at www.cqc.org.uk.

The service did not have a registered manager in place at the time of our inspection. 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 and associated Regulations about how the service is run.

We found improvements had been made in identifying risks to people arising from their care needs and in

Summary of findings

managing risks correctly to ensure people's safety. Further improvements were still required in relation to the management of medicines, the management of people's healthcare and monitoring the quality of the service.

We found that improvements had been made in relation to the service ensuring that people's rights were protected. We found during this inspection that the requirements of the Mental Capacity Act 2005 were being adhered to. Applications had been made to the appropriate authority if this was required under Deprivation of Liberty Safeguards (DoLS). DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

Systems used to monitor the quality of the service provided were still not effective despite improvements made to these.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Appropriate systems were in place to protect people from the risk of abuse and risks to people were identified and acted upon.

Improvements were required to management of medicines. Although systems had been improved they were not always effective in picking up issues identified during this inspection.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during or next planned comprehensive inspection.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were not always supported effectively with their ongoing healthcare.

People were supported with decision making in the service and legislation which protected people's rights was being adhered to.

Is the service well-led?

Inadequate

The service was not consistently well led.

Improvements were required to ensure people were confident in expressing their views or raising any concerns. The manager was not registered.

Systems for monitoring the quality of the service had improved but further improvements were required.

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during or next planned comprehensive inspection.

Stoke House 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.

We undertook an unannounced focused inspection of Stoke house Care Home on 26 November 2015. This inspection was carried out to check that improvements to meet legal requirements after our comprehensive inspection on 27 and 28 July and 7 August 2015 had been made. The team inspected against three of the five questions we ask about services: is the service safe, is the service effective and is the service well lead. This was because the service was not meeting some legal requirements and we had taken enforcement action which required the service to improve in these areas.

The inspection team consisted of two inspectors, a specialist advisor who was a nurse 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with five people who were living at the service and four people who were visiting their relations. We spoke with two nurses, the manager, and three care workers.

We looked at the care records of seven people who used the service, as well as a range of records relating to the running of the service, which included audits carried out by the manager.

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.

Inadequate

Is the service safe?

Our findings

The last time we inspected the service we found there were improvements needed in relation to the safety of people. This was because staff were not always aware of the process of reporting allegations of abuse, risks to people were not always being identified and acted upon and medicines were not being managed safely. We told the provider they must make improvements to protect people from the risk of harm. During this inspection we found that some improvements had been made but there were still improvements needed in relation to the management of medicines.

At our last inspection we found that improvements were required to ensure that people received their medicines at their most effective. Both staff and management identified medicines management as an area that required further improvement. We found this to be the case during our inspection and that improvements were still required in relation to the management of medicines.

We found that not all liquid medicines or external creams were labelled with the date of opening. Staff were aware of the need to record the date of opening to ensure that the medicine was being used within the correct time period to ensure their effectiveness, but this had not been done for all medicines.

We found that guidance was in place for some medicines which were prescribed to be given when required (known as PRN) but not for others. For example, one service user had a PRN protocol in place for one medicine but not for another. This meant that there was a risk that people would not receive their medicines as intended by their doctor. In addition we found that although records were in place to record where medicine patches should be applied, not all of these were consistently completed to ensure that the medicine patch was applied to be at its most effective.

We found that further improvements were required to the administration of medicines to ensure that people received their medicines as prescribed. People could not be assured checks were carried out to ensure they were given any controlled drugs safely. We found that on two occasions the administration of a controlled drug had not been witnessed to ensure the correct medicine was given to the intended person. Additionally we found that two people had not received their prescribed medicines as staff had been waiting for the results of a blood test. There was no record of any contact with other healthcare professionals to determine whether this was the correct course of action. Therefore improvements were required to ensure people received their medicines as prescribed and that records were checked to reduce the risk of error.

Improvements that had been made to the administration of medicines were that people's medicines administration records (MAR) had a photograph of the person to help ensure the correct person was given the medicine. Also there was information about whether a person had any allergies and how they liked to take their medicine.

People told us that they felt safe at the service. One person told us, "I have no reason to feel unsafe." The relatives we spoke with also felt that their relations were safe. One relative told us, "I feel safe because over the years, there's been a continuity of staff. They've always got to know us, everything that's a bit more serious, they will be on the phone to tell me."

We found that people were supported by staff who were aware of their responsibilities to refer allegations of abuse to the local authority. Staff told us that the procedure for responding to safeguarding allegations had been discussed at a recent staff meeting and there was information displayed within the service for staff to refer to. We found this to be the case. One nurse told us they had contacted the local authority safeguarding team for advice when they had identified a concern and had been given guidance on the situation. We saw records which showed the provider had shared information with the safeguarding team as appropriate.

During our last inspection we found that risks to people were not always identified or appropriate action taken to reduce the risks. On this visit we found that risk assessments were in place in relation to areas such as falls and pressure ulcers and these had been regularly reviewed to ensure that information was current. We looked at the care records of one person who had a high risk of falls. The person had a risk management plan in place which had been kept up to date. We observed that the person was supervised by staff in line with guidance in the care plan. This reduced the risk of injury to the person.

We found that improvements had been made to ensure the safety of people who used bed rails. During this visit we saw that people had risk assessments in place to determine

Inadequate

Is the service safe?

whether they required bed rails. We saw that alternative options for keeping people safe had been explored and were being used and monitored appropriately. This reduced the risk of bed rails being used unnecessarily.

Requires improvement

Is the service effective?

Our findings

The last time we inspected the service we found there were improvements needed in relation to the management of people's ongoing healthcare and to ensure that legislation which protected people's rights was being adhered to. During this inspection we found that improvements had been made to the way that decisions were made about people's healthcare and the Mental Capacity Act 2005 (MCA) was being adhered to. We found that improvements had been made in the management of people's healthcare but that further improvements were still required.

During this inspection we found that people at risk of skin damage had risk assessments in place which were regularly reviewed. However records did not support that people received the positional care as described in their care plans that they required. Three people who required regular repositioning did not have records completed to show they had received this care. Therefore the provider could not be assured that repositioning changes were being carried out at the recommended intervals. In addition to this people who used airflow mattresses to reduce the risk of pressure ulcer formation were placed at greater risk of skin damage because checks carried out on airflow mattresses did not ensure they were at the correct setting required for the person using it. This increased the risk of harm to people as the mattress should be at the correct setting for the person to effectively reduce the risk of a pressure ulcer.

We found that people may not receive the treatment they require to enable wounds and ulcers to heal. We found one person who required treatment to a wound did not have a care plan to inform nurses on what treatment was required, including the frequency of dressing changes. Although we saw that the wound was being regularly assessed, the nurse we spoke with was unaware the person had a wound that required treatment. There was a risk that the person would not receive sufficient support as not all staff were aware of the wound and there was no guidance in relation to wound management.

During our last inspection we identified that there was a risk that people could lose weight without this being recognised by staff in a timely manner to prevent deterioration in their health. At this inspection we found three people who were identified as being at risk of not having sufficient nutrition. Care plans stated that the three people should be weighed weekly to monitor for any weight change. We found that these three people had not been weighed at the recommended frequency. Although appropriate measures were in place for one person who had lost weight, there was still a risk that staff would not respond to changes in weight in a timely manner.

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

We found at our last inspection that guidance was not always clear and on one occasion was contradictory. Improvements had been made to care records about the management of people's healthcare conditions and these now contained clear guidance for staff. The staff we spoke with during this visit were aware of guidance contained within care records and were able to describe how they would respond to changes in people's healthcare conditions to reduce the risk of harm to the person.

People we spoke with told us that they felt able to make their own decisions and that staff asked for consent before carrying out interventions. One person told us, "Oh yes I make my own decisions. I can decide when to get up and go to bed. I have a choice about where to have meals."

During this inspection we found that improvements had been made to how people were supported to make decisions and protected under the Mental Capacity Act 2005 (MCA) when they lacked capacity. 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. We saw that MCA assessments had been completed and decisions made in people's best interests in the event that they lacked capacity.

We saw that applications had been made to the appropriate authority in the event that people were deprived of their liberty. 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). We were told that seven applications had been made at the time of our inspection.

Requires improvement

Is the service effective?

During our last inspection we found that some people had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place which had not been appropriately completed. The form did not show whether the person had the capacity to decide if they wished a DNACPR to be in place for them, or who had been consulted regarding the decision for one to be in place. At this inspection we found where people had a DNACPR form in place people's rights were being respected. This ensured that people's end of life wishes and needs were considered and acted upon.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that there was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulations and resulting in negative outcomes for people who used the service. We took enforcement action against the provider in relation to Regulation 11, Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this visit we found that there had been improvements made in Regulation 11, but more improvements were needed in Regulation 12 and Regulation 17.

During our last inspection we found that systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff were ineffective. During this inspection we found that systems to ensure that people who used the service were given the opportunity to raise their concerns and express their views still required improvement. This was because the people we spoke with were not aware of how they could raise concerns or whether there were meetings they could attend to discuss the running of the service.

We found that improvements were still required to ensure that people received the standard of care they expect. A staff member told us they had not reported verbally or in writing an incident of poor practice they had witnessed several days previously. The staff member said they had discussed the incident with the member of staff concerned but they had not yet written a statement or reported it the manager as they had not been at work for several days. This meant that systems were not effective in ensuring that incidents which occurred in the service were dealt with in the most appropriate way to ensure the safety of people.

One relative told us that communication with them about their relation could be improved. A staff member told us that they felt that communication between the management team and staff team needed to be improved. They said staff were not always given information about the service they needed in a timely way. For example they had not been kept informed of developments within the service in a timely manner since our last inspection.

On this inspection we found that an audit carried out on medicines management had failed to identify incorrect practices were being followed.

There was not a registered manger in post. There has not been a registered manager at the service since the last registered manager was deregistered in November 2014. Since our last inspection, a new manager had been recruited and taken up post. The manager told us that they had started the process to apply to become the registered manager. We checked our records and found the provider had sent us notifications of events they are required to inform us of.

Relatives were aware of meetings where they were kept informed of changes within the service and where they could raise concerns. Several of the relatives we spoke with were aware of the provider's action plan to address issues within the service which were identified during our last inspection. The relatives felt that there had been some positive changes since our last inspection and we found that some improvements had been made. One improvement was there was now guidance followed to determine appropriate staffing levels.

The provider had recently carried out a number of audits to identify any areas of service that required improvement in areas such as catering, infection control and health and safety. The audits were thorough and an action plan had been produced with timescales set for when these actions should be completed by.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment** Care and treatment must be provided in a safe way for service users.