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Stamford House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection tool place on 16 and 17 July 2018. Our visit on 16 July 2018 was unannounced.

Stamford House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

During the last inspection of Stamford House in July 2017 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to infection control, cleanliness of the environment and equipment, moving and handling, and monitoring of people's dietary intake. The service was rated as requires improvement in the safe, effective, caring and well led sections of the report and good in the responsive section. The service was rated as requires improvement overall.

Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'is the service safe?', 'is the service effective?', 'is the service caring?' and 'is the service well led?' to at least good. At this inspection we found improvements in these areas and the service was no longer in breach of the regulations.

Stamford House provided a safe and secure environment. Environmental risks were assessed, people's vulnerability recognised and safeguards to prevent avoidable harm were in place.

Appropriate measures were in place to prevent the spread of infection. A cleaning schedule showed attention to ensuring tasks were carried out in a timely fashion, and supervision notes and team meetings reminded staff of their duties to ensure a clean and hygienic environment.

People's diets were closely monitored and records were kept to show people's daily food and drink intake. There was a plentiful supply of hot and cold drinks, and people told us that they enjoyed the food provided.

Stamford House Care Home is an older type property situated in Rochdale, Greater Manchester. The home is registered to provide accommodation to 23 older people who require support with personal care. There are two passenger lifts to assist movement between the ground and first floor. En-suite facilities are not provided but there are assisted bathing facilities on both floors. At the time of our inspection there were 15 people living in the home.

There was a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Systems in place to manage and administer medicines helped ensure that this was done safely. Attention

was paid to people's health needs with close liaison with doctors, district nurses and other health professionals as the need arose.

There were safe recruitment procedures in place to ensure staff were of the right character to support vulnerable people. Training provided staff with ongoing opportunities to develop their learning. Staff were knowledgeable and knew the people they supported. Regular observation of their performance allowed for on the job supervision, and staff had opportunities to discuss their progress and work performance through supervision and yearly appraisal.

Individual choices were acknowledged and people who lived at Stamford House told us their choices were respected. Where people lacked capacity, the appropriate agreement to provide care and support had been authorised by the local authorities commissioning the service.

The needs and wishes of the people who lived at Stamford House were uppermost, and we saw staff showed genuine warmth towards them. There was a person-centred culture and personal belongings were treated with respect.

Care plans and daily notes provided sufficient detail to guide staff who might be unfamiliar with the people being supported. They gave a good account of needs and wishes, with regular reviews and vigilance to any changes in need. There was evidence of consultation with people and their relatives. When the service received complaints, these were followed up; we saw evidence of investigation and outcomes were recorded. People told us that they knew how to complain but did not need to. One person told us, "Everything is alright here. It's really good; I've got nothing to complain about."

We witnessed good cooperation and communication amongst staff, who were aware of their responsibilities. People who used the service were stimulated, and had bonded with the staff and formed friendship groups amongst themselves. The home conveyed a content and convivial atmosphere where people felt at home.

There was good day to day management of the service. The management team were respected, visible and supportive to both staff and the people who used the service, ensuring standards of care were maintained.

We saw information was audited but the data gathered could be used to further develop the service and improve the quality of service provision. However, the views of people who used the service were sought and respected. It was clear that Stamford House was their home, and the service was responsive to their needs and wishes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they were supported by staff who knew them well. The presence and vigilance of staff helped them to feel safe.

Environmental and individual risks were well managed. Infection control measures were in place. Equipment and supplies were regularly serviced.

Recruitment procedures ensured appropriate candidates were chosen to work at Stamford House. There were enough staff on duty to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were well trained and understood the needs of the people who used the service.

People enjoyed the food provided and their diet was appropriately monitored.

Staff worked within the principles of the Mental Health Act.

Is the service caring?

Good

The service was caring.

People were happy with the care they received.

People were consulted and assisted in drawing up their care plans.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's needs and how they would like them to be met.

People told us that they had enough to do to keep them occupied.

Any complaints or issues of concern were looked into and appropriately dealt with by the registered manager.

Is the service well-led?

Good

The service was well led.

People spoke positively about the registered manager, and staff worked well as a team.

The registered manager checked the quality of services provided and met regularly with people who used the service to ensure they were receiving the right level of support.

The service had policies and procedures to guide staff on the delivery of all aspects of care and support.

Stamford 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 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.

This inspection took place on 16 and 17 July 2018 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Stamford House, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

Before our inspection we contacted the local authority safeguarding and commissioning teams to obtain their views about the service. They raised no concerns with us.

During our visit we spoke with the registered manager, deputy manager, three care workers, the activity coordinator, a cook and a domestic assistant. We observed how staff interacted with people and spoke with eight people who used the service, one visiting relative and two visiting health professionals. We looked around the building, including all the communal areas, toilets, bathrooms, the kitchen, and the garden.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for four people, and nine daily records, four staff personnel files, and other documents related to the management of the home, such as maintenance records and service invoices. We also checked nine medicine administration records.

Good

Is the service safe?

Our findings

At our last inspection we rated the safe section as requires improvement. At this inspection we found that improvements had been made and re-rated this section as good.

When we inspected Stamford House in June 2017 we found the service was in breach of Regulations 12 Safe care and treatment and 15 Premises of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient arrangements in place to control and prevent the spread of infection, and to ensure the cleanliness of the home and equipment.

At this inspection we found improvements had been made. There were systems in place which protected people and staff from infection and cross infection, and when we toured the building we found it was clean. One person who used the service told is, "Its fine, all clean; the way I'd like it". All staff had attended refresher training in health and safety and food hygiene and were reminded of their responsibility to maintain a clean and healthy environment, as recorded in supervision notes and staff meetings.

The service employed a domestic assistant, with responsibility for ensuring all areas of the home were clean and safe. A detailed list of daily and weekly tasks was checked and signed to show cleaning had been complete. This list included areas such as the tops of wardrobes, doors and drawer handles, carpets, blinds and radiator covers. A senior care worker had been appointed to monitor hygiene and infection control who oversaw an equipment cleaning rota to ensure all equipment, including hoists, lifting belts, commode and shower chairs, walking frames and wheelchairs and weighing scales were fit for purpose.

Following a visit from the local authority infection prevention and control team in September 2017 the service had produced an action plan detailing the steps required to ensure high standards of infection control would be maintained. At our inspection we saw all actions had been addressed, for example, the care plans we looked at had been reviewed to include risk assessments outlining measures to minimise the risk of infection.

Staff we spoke to clearly understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Disposable gloves and aprons were available from well stocked dispensers conveniently situated on corridors. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Hazardous items such as cleaning materials were stored safely when not in use.

A full infection control audit was undertaken monthly, in addition to specific audits checking staff hand hygiene, mattresses and bedding, and decontamination of equipment. Where issues were identified, records showed evidence of follow up action.

When we inspected Stamford House in June 2017 we found that recommendations following a legionella risk assessment had not been fully carried out. Legionella is a bacterium that can result in serious illness

such as pneumonia. Since the last inspection follow up action has been taken to ensure the home was protected from the risk of legionella, including temperature monitoring and six-monthly tank inspections to ensure compliance.

Stamford House provided a safe and secure environment for the people who lived there. The front entrance was kept locked to prevent unauthorised persons from entering the home. When we arrived we were asked for proof of identity and to sign into the visitor's book. There was also a safety unlocking system in place on the front door. This was used to help prevent people who were considered as being at risk if they went out alone from leaving the premises.

The staff we spoke with were conscious of the vulnerabilities of the people they supported. For example, one care worker told us, "Safety is paramount. We always check equipment before use, and know how to use it. We always read care plans and are told of any changes at handover, so we know what support people need." When we asked them, the people who lived at Stamford House told us the vigilance of staff to their welfare made them safe. One person said, "I feel very safe because staff are always checking on me. I know if anything happens there'll be someone there." Another person remarked, "I've been in places like this before but this really stands out, the staff understand us, and that makes us feel secure.". They told us that staff recognised their anxieties and responded to their needs. One person told us, "[The staff] keep me safe … If I wasn't here I would feel uncomfortable; here I feel there is always someone around to make sure I feel okay".

Prior to their admission many of the people had lived alone and neglected their care needs or had been diagnosed with alcohol related dementia. They were supported to maintain the positive aspects and influences of their life in the community including friends and other support networks from the safe and secure environment of the home. Risks were measured to support people to lead a healthier lifestyle. One person told us, "I feel safe here, the staff help, but let me get on with my life."

We saw that suitable arrangements were in place to help safeguard people from abuse. The service had a safeguarding policy in place and staff understood their responsibilities to protect people from harm and report any issues of concern. The training records we looked at showed staff received safeguarding training and they confirmed this when we spoke with them. The registered manager kept a log of any instances of suspected abuse. Since our last inspection three allegations of abuse had been reported to the local authority. We saw that in each instance protective measures were put in place to minimise the risk of harm and a full investigation was carried out. The safeguarding log also included any incidents where injuries appeared to be accidental. For example, when people had fallen in their room, and were able to tell staff what had happened. We saw appropriate recording of these incidents, and body maps indicated any cuts or bruises, but these had not been reported as safeguarding concerns to the local authority. We discussed with the registered manager how they could ensure incidents were appropriately reported to ensure transparency and to consider ways of reducing any further occurrence. Further training had also been commissioned from the local authority to update staff knowledge around mental capacity and managing safeguarding allegations.

As we looked round the building we saw that day to day risks were well managed. Where cleaning was in progress, the domestic staff placed signs warning people of wet floors. Environmental risks had been assessed and appropriate action taken. Staff were vigilant to any new or emerging environmental risks, and the registered manager would regularly check any issues regarding lighting, heating or flooring which might indicate trip hazards. Staff had access to a mobile phone app which they could use to report any day to day maintenance issues: any concerns could be raised and reported to the maintenance team and ticked off once complete. This was then downloaded to a computerised document recording all maintenance activity and outstanding issues each month.

Walkways and corridors were clear and free of any clutter. Regular fire drills and tests were undertaken, and everyone living at Stamford House had a personal emergency evacuation plan (PEEP). These explained how each person would be evacuated from the building in the event of an emergency. An ongoing maintenance plan showed that the nurse on call system had recently been renewed and at the time of our inspection work was ongoing to replace emergency lighting throughout the building.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The registered manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker. The service also had a business continuity plan in place. The plan contained details of what action needed to be taken in the event of an emergency or incident occurring such as a fire or utility failures.

We looked at four care records, which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, nutrition and hydration, communication and personal hygiene, including oral care. Risks identified had corresponding care plans to help reduce or eliminate the identified risks, which were reviewed monthly. For example, where one person consistently refused to shower a risk assessment recognised the person's right to make their own decisions but considered the dangers of unwanted social stigma and becoming unwell. A corresponding action plan provided staff with guidance to manage the person's personal hygiene. When we asked, people told us that they were consulted and given information about the risks to their safety, and helped to make appropriate choices. We saw measures were in place to prevent injury or harm. For example, where people were at risk of falls during the night, crash mats had been put in place to help reduced the risk of harm. Call bells were accessible to allow people who used the service to summon help.

The recruitment procedures in place gave clear guidance on how staff were to be properly and safely recruited. We looked at four staff files. These included a recent photograph and proof of identity, an application form that documented a full employment history and accounted for any gaps in employment, a job description, proof of eligibility to work in the United Kingdom and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Stamford House.

When we asked people if they thought there were enough staff to meet their needs they told us there were. One person told us, "Yes, there is always someone around, and if I need help when I'm in my room I never have to wait long, even at night." Staff told us they were kept busy but believed they had enough time to accomplish their tasks. They explained that they shared daily duties which afforded them time to spend with the people whom they supported.

We looked at the rotas for the past three weeks which reflected the number of staff on duty on the days of our inspection. In addition to the registered manager and deputy manager, three care workers were on duty during the day. At night there were two waking staff. The rotas showed no changes or unplanned leave and we were told where staff were unable to complete shifts due to illness or other factors, regular staff would provide cover. This meant that people were supported by care staff who knew them well. There was a low staff turnover, with many of the staff employed having worked at Stamford House for ten years or more.

Senior staff were trained to administer medicines, and their competency was checked annually. A visiting

pharmacist expressed confidence in the service's ability to safely manage medicines, for example, they would inform the pharmacy if there was ample stock of build-up drinks or creams prescribed to be used as required. This helped to prevent the over stocking of medicines. They told us that staff regularly consulted the pharmacy and had established good communication regarding any medicines used by people at Stamford House. The pharmacist confirmed that medicines would be ordered on a 28-day cycle, eight days prior to the start of the cycle and confirmed prior to delivery.

All medicines were stored in a locked treatment room. Both the fridge and room temperatures were recorded daily. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. The deputy manager or senior care worker on duty would hold the keys, and medicines were dispensed from a lockable trolley using a monitored dose system (MDS), which helped to minimise the risk of incorrect administration.

We observed a member of staff giving out medicine during our inspection. This was done in a person centred way, with the member of staff ensuring the person was comfortable, and provided with a drink to help with swallowing. They were patient, staying with each person and talking with them until they had taken their tablets. They then recorded on the person's medication administration record (MAR) sheet that they had received their medicines as prescribed and at the right time.

We looked at eight MAR sheets. Each included a photograph of the individual, and noted any intolerance to medicines and allergies. The records we checked were accurate, up to date and matched the medicines in stock. There were no gaps in signatures. Some medicines had been prescribed to be given 'PRN', or as required. We saw protocols were in place to instruct staff when these could be administered, and we saw that these had been recorded on the MAR. Although there were no medicines administered during the night at the time of our inspection, a senior care worker trained to administer medicines was always on duty should any person require any PRN medicines.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. We saw controlled drugs were stored in a locked cabinet, and the controlled drug register was checked daily at the start and end of each shift and countersigned when administered. We checked the balance of controlled drugs for one person and found them to be correct.

The medicine fridge contained eye drops and some creams which required storage at a low temperature. We saw that these were in date with the manufacturers guidance, and the date tubes were opened was noted, so that if they were not used within the permitted timescale they could be safely disposed of. We saw that all unused medicines were returned regularly to the pharmacy for destruction and to avoid any stockpiling of medicines.

Good

Is the service effective?

Our findings

At our last inspection we rated the effective section as requires improvement. At this inspection we found that improvements had been made and re-rated this section as good.

We found a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as there were concerns about the recording of people's food intake. At this inspection we found people's weight and diet were monitored. Weight charts were kept up to date and malnutrition universal screening tool (MUST) scores were reviewed monthly. MUST is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity.

Where poor food intake had been identified as a risk we saw that appropriate steps to minimise the risk had been taken. Each person had a 'food diary', and if necessary food and fluid intake was recorded. The care records we looked at showed nutritional risks were assessed and reviewed, and if there was any weight loss referrals to dieticians or other health professionals were made. Advice was followed; care plans, which were shared with kitchen staff, gave clear instruction. For example, 'high energy puree diet, little and often. Provide snacks.'

Kitchen staff showed a good understanding, not only of people's preferences, but also how they would need their meal to be prepared, such as fortified meals to build weight, or food to be of a certain consistency to aid swallowing. A list in the kitchen also indicated any people who required a specific diet due to medical conditions such as diabetes. At the time of our inspection nobody required a specific cultural diet. When we spoke to kitchen staff they told us that they had supported people in the past who needed their food to be prepared in accordance with their religious values.

Throughout the day we saw drinks and snacks, including fresh fruit and biscuits were offered. Cold drinks were provided and people could help themselves to juice which was available in covered jugs in both lounges, and regularly replenished. The main meal was served at lunchtime with a choice of two hot meals and a dessert. If people did not want either they could ask for an alternative. On the first day of our inspection one person asked for sandwiches and said a hot meal would be over facing. This person asked for, and was brought a plate of sandwiches and told, "If you want any more please let me know."

People told us that they enjoyed the food provided. At breakfast one person showed us their empty plates and exclaimed, "Weetabix, then tomato and bacon! Plenty of tea and cold drinks. What more would you want!" When we asked other people, they made comments such as, "The food is really good, especially the puddings", and, "It's smashing!" People told us that they were asked about the type of food they liked and this was reflected in the menu. They told us they received the right sized portions. One person told us, "The food is brilliant. It's my kind of food. We're never overfed and always get enough.

Lunch was a sociable occasion. People were supported into the dining room and offered a choice of where they wanted to sit. Staff were attentive to people's needs, for example we overheard a care worker addressing a person kindly and inquiring, "Are you alright sitting there, or would you prefer to come over

here where it's a bit cooler?" Tables were set with menus, cruets, tablecloths and napkins. Some people were offered and accepted clothes protectors to avoid dropping food on themselves. Staff wore disposable protective aprons, and supported people who had difficulty eating.

Prior to their admission into Stamford House, people received a full assessment of their needs by either the registered manager or deputy manager. This pre-admission assessment looked at how their needs and wishes could be met, with consideration of the needs and compatibility of the other people who used the service. When we looked at care records we saw that they included the views of people who may have been involved in care and support such as family members. Records also included any assessments completed by health and social care professionals such as social workers or occupational therapists. This information was then used to form an interim care plan so staff would understand the needs and wishes of the person and how best to meet them from the moment of admission.

Some of the people staying at Stamford House at the time of out inspection had been admitted for 'pre-assessment'. This was an arrangement which allowed the person and other people involved in their care to consider if their longer-term needs could best be met in a care setting or if they were able to return to their own home. This approach enabled a safe and timely discharge from hospital for people who no longer needed to be in a hospital but were unable to return to their own home. In these cases, a 'trusted assessor' approved by the NHS and the service would provide the information used to from the interim care plan. Social care and health staff would liaise with the service to consider the persons needs in the long term, whilst the service provided the necessary care and support to enable the person to achieve their full potential.

People who used the service received effective care and support from well trained and well supported staff. Many of the people who worked at Stamford House had done so for a number of years and had developed a sound knowledge of the people who used the service and how they liked their needs to be met. Discussions with the registered manager, observations of and conversations with staff showed they had an in-depth knowledge and understanding of the needs of the people they were looking after.

Prior to working with people who used the service staff told us that they had been given a good induction into the service, which covered all aspects of provision and allowed time to get to know the people who lived at Stamford House. During this period key training linked to the Care Certificate was delivered, such as moving and handling, infection control, first aid, and food hygiene. The Care Certificate is a nationally recognised qualification for people working in the care sector which provides the essential knowledge to ensure new care workers have the required competence to care for people safely and effectively. Previous training and experience was acknowledged and records indicated that staff had further qualifications in care, such as national vocational qualifications (NVQ) or diplomas in health and social care. At the time of our inspection the registered manager and provider were supporting three staff to complete higher level qualifications.

Staff were expected to complete refresher training in all necessary aspects of their role on a yearly basis. This meant that they were aware of any changes to legislation and best practice, to ensure people received the safest possible care. We saw from the training matrix that most training was up to date, but there were gaps where staff had not all completed mental health or end of life refresher training. We spoke to the registered manager, who told us that this training had been commissioned for later in the year.

All staff received mandatory equality and diversity training renewed yearly to ensure they were aware of how best to meet religious, sexual or social needs in a way which reflected people's culture and beliefs.

Staff had a yearly appraisal which gave them the opportunity to reflect on their work and set targets for the following year but they did not always receive a formal supervision with their manager. A supervision policy stated that staff were to have six supervision sessions with their line manager each year, but the service had not kept up with this. A wall chart indicated when each member of staff was due to receive a formal supervision session with either the manager or the deputy, but some of these had been missed. When we spoke with the registered manager they told us that meeting the needs of the people who used the service was the priority and this had led to supervision sessions being postponed. The staff we spoke with concurred, but told us that they received appropriate 'on the job' direction and support, and felt comfortable speaking to the registered manager at any time during their shift. One told us, "I get supervision, but if I have a problem I can go and talk to [the registered manager]. They will always listen". We looked at four supervision records and saw discussions relating to performance, issues relating to the needs and management of the people who used the service, and staff training needs.

People had good access to healthcare and staff monitored their physical and mental health needs. Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity.

A visiting health professional told us that the staff were vigilant to people's health needs and would contact them if there were any issues; were keen to follow instruction and, "The staff are busy, but always make time to help. They are knowledgeable and know the residents well. This helps us to deal with any medical issues quickly and efficiently". We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

The building was suited to the need of the people who lived at Stamford House. People had access to space; each had their own bedroom which they could keep locked if they wished, and were personalised to reflect their tastes and interests. There were two lounges, and a separate dining room; people were free to congregate and move from one to another, or throughout the building. The laundry and areas holding hazardous substances were kept locked to ensure safety. At the back of the building was a large garden area, which was well maintained by the staff, who encouraged people who used the service to help with planting and landscaping.

Dementia friendly signage helped to orientate people to time and place, and fire exits were clearly marked. A collage of photographs displaying people who lived at Stamford House involved in various activities was on display near the main office and was affectionately referred to as the 'memories board'. A notice board near the entrance included the complaints policy, suggestions and complaints forms, and leaflets about reporting and preventing abuse, advocacy services, and healthcare provision in the area. Information on display in staff area reminded staff to check for signs of poor skin integrity, information about diet, urine infection management and safeguarding information for staff. Training certificates were also displayed.

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. People told us that they were supported to make their own choices. For example, one person said, "The staff are all OK, they never give me any grief. I can stay up 'til late, and have a lie in. They don't mither me too much about smoking, as long as I smoke outside". Choices were offered and respected, for example, we observed one person being asked if they would like to go to dining room for lunch but chose instead to have their meal in the lounge.

People told us their decisions were respected; one told us, "I'm going out. That's all they need to know. They

treat me right. They know me, they make sure I'm OK. I've got freedom and security here. I have friends here; all the staff are my friends". Staff recognised people's rights, encouraging personal independence and supporting autonomy, but were mindful of people's needs and encouraged them to make decisions which supported their general health and safety. People were provided with support and information to reduce risks. For example, a few the people who lived at Stamford House smoked. They had been offered e-cigarettes as an alternative, but we were told by the registered manager that all had tried to use them, but reverted to tobacco. One person we spoke with confirmed this, telling us they didn't get the same feeling from 'fake cigs'.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Stamford House was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw information to show that two applications to deprive people of their liberty had been authorised by the supervisory body (local authority), Where these authorisations had been granted the service had informed the Care Quality Commission. Where a DoLS had been authorised, the information was stored within the person's care records.

Where people appeared to lack capacity, records showed that the service had conducted capacity assessments to determine if the person was able to understand, weigh up, and communicate their decision. Some people were seen to lack capacity to make certain decisions but staff recognised that this did not mean they were unable to make any decisions themselves. For example, one care plan noted a person could decide when to eat but could not always state what they wanted. Staff were instructed to show the person different choices and help them to make their own choices of meal. Care records would indicate what decisions people could and couldn't make, and care plans provided some guidance on how to support people to make their own decisions.

Good

Is the service caring?

Our findings

At our last inspection we rated the caring section as requires improvement. This was because of concerns about one person's appearance. At this inspection we found that improvements had been made and re-rated this section as good.

People who lived at Stamford House told us that their needs were met in a caring and compassionate manner. One person told us, "I've been here a long time and wouldn't move anywhere else. This does me fine. Carers look after us, the staff are calm and patient. They never lose their tempers. Some of the [other people who use the service] can be noisy, but the staff calm them down quickly." A visitor told us, "All the staff are all kind and good, they show they care. [My friend] is happy and contented."

Stamford House had a statement of purpose and a vision statement which read, '[We] provide a high standard of care' and 'promote and encourage all aspects of independence and freedom'. We saw people were encouraged to do as much for themselves as they could whilst the home provided a safe and secure environment to minimise any risks to their individual autonomy. Staff showed a good understanding of the religious, cultural and social background of the people who used the service.

Staff had time to sit and talk with people who used the service. One care worker told us, "We're busy but can always find time to sit and listen to [people who use the service]. That's the real fun part, we can have a laugh and a giggle with them." We noticed that when writing up daily notes, staff members would sit in the lounge where they could join in conversations with people who used the service. Throughout our inspection, we saw that people were treated with kindness by all the staff, who were warm, friendly and open. We saw all staff would stop and talk with people who used the service, showing patience and kindness. For example, we observed the domestic assistant walking by a person who used the service, and addressing them by name, asked if they'd like to be fanned (it was a hot day), and then rapidly waving a sheaf of paper to help then cool. They then offered and brought over a cold drink. When assistance was required we observed that people did not have to wait for long. Carers gave positive encouragement and support when assisting people to mobilise.

Staff knew the people well. For example, the activity coordinator told us that one person who used the service would not always engage and explained, "I judge the mood and approach them appropriately. Sometimes they will cooperate, I don't force it; we need to go at their pace to stimulate and engage with them."

We observed care workers sitting quietly with people, making eye contact and chatting quietly, or sitting with groups and supporting conversations. All showed positive regard for people who used the service and treated them with dignity and respect. A poster in the staff area reminded staff of the ten 'Dignity Do's': a list of actions to ensure that people were always treated respectfully. We saw staff responded to people's anxieties in a calm and measured fashion, helping to put them at their ease. Interactions were kind, patient and person centred. For example, we observed a care worker assisting a person to eat their meal. The person was encouraged to do as much for themselves as they could with appropriate prompting, but when

they began to struggle the care worker kindly provided assistance. Throughout, the care worker offered good conversation, sat at the person's level and maintained eye contact. The person was not rushed and allowed to eat at their own pace.

Staff were alert and watchful for any changes in need or appearance. On the second morning of our inspection a care worker noticed one person was beginning to tire, and offered to escort them back to their room. They understood when people required assistance, but supported them to remain independent where they could. When one person splashed some of their drink and was attempting to wipe this up, staff fetched them clean tissues, and checked they were all right. Concerns were noted and recorded. In one care record we saw a note which read, 'had a general chat about how [person] was feeling; appears a little confused. Referred to doctor for potential UTI [urinary tract infection]. Also spoke with daughter.'

Spiritual and cultural needs were catered for. Local places of worship were listed on the main noticeboard and people were supported if they wanted to attend service. At the time of our inspection no one who used the service had any specific cultural or religious needs, but we were told they would be met. For example, we were told of one person who had recently lived at Stamford House who was a member of a specific Christian religion. Staff could tell us some of the social, dietary and medical norms for this religion and how they had taken time to find out what was important to the person.

People were involved in discussions around issues which might affect their comfort and well-being. For example, following a mattress audit one person's mattress was no longer fit for purpose, but the person was happy with it and did not want to change. Through discussion and negotiation with this person an agreement was reached to purchase a bigger bed with a new mattress, to the general satisfaction of the person.

Due to their previous lifestyles and other factors, some of the people who lived at Stamford House had lost touch with their relatives. Where necessary, the service would help them to find advocates. An advocate is an independent person who can support vulnerable people to have their voice heard on issues that may be important to them. We were told that one person who lived at Stamford House had an advocate who visited them regularly, and saw their visits were documented in the person's care records, and that they were consulted about any decisions made. Information was available for any other people who wanted assistance and support.

Visitors to the home told us that they were made welcome when visiting the home. They told us that they could visit at any time. One visitor told us, "It's alright here, and right for the people living here. I am always treated well when I arrive." We saw that staff knew people's relatives, addressed them by their preferred name and were always welcoming.

Each person had their own room. Keys to their room were available and there was space for storing private belongings if people wanted this. Privacy was respected. For example, staff would knock on people's doors or ask for permission before they entered bedrooms. We saw that people's personal belongings were treated with respect, and privacy was respected. Information held about people, including all care records were securely stored in locked offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to their notes and we saw that they regularly consulted care plans and assessments to ensure that they were providing appropriate care and support.

Good

Is the service responsive?

Our findings

At our last inspection we rated the responsive section as good. At this inspection we found that it remains as good.

People told us that staff responded to their needs and provided them with support when they required it. One person said, "Everything is alright here. It's really good; I've got nothing to complain about." A visiting health professional remarked to us, "The staff are friendly and they know the needs of the people who live here. They are all approachable, no matter who you talk to they can give a good summary of [the person's] condition. They are helpful and polite, and follow instructions well.".

People told us that they were supported in the way they had agreed and the staff knew what they liked and disliked. We saw they were asked about how they liked their care to be delivered and care plans documented any conversations with family members. The care records we looked at showed that people had been consulted in drawing up and reviewing care plans.

Care records provided enough information about individuals to enable care staff to meet their needs. We looked at four care records. Each included a recent photograph of the person and a signed form to indicate their consent. Where people were unable to consent, this was noted and signed by a relative. A section near the front of each care file entitled 'My life so far' provided details of the person's life history, including any past occupation, family history and areas of interest. This would help anyone unfamiliar with the person to understand a little of their background, interests and family life. Twenty separate sections provided information and instruction to staff about various aspects of care and activities of daily living, such as maintaining a safe environment, communication, eating and drinking, breathing, controlling body temperature, and any recorded wishes for end of life care. This ensured that no aspect of need was overlooked. Each care record contained generic assessments of risk, and a corresponding care plan would indicate how to minimise the risk. For example, where waterlow scores indicated a person was at risk of poor skin integrity a corresponding care plan and turning chart detailed actions taken to minimise the risk of sores developing, and reflected discussion and instruction with the district nurse. Mitigating factors were recorded, including the type of pressure relieving mattress and use of pressure cushions.

Notes of any visits from health or social care professionals were kept on records, and a section entitled 'other information you might need to know' included copies of any accident or incident forms, pre-admission assessments and an inventory of any property owned by the person. Attention was paid to people's oral health and care plans indicated any assistance they might need. The service had an 'oral health champion' who monitored and checked that people's oral hygiene was good.

Care plans reflected people's age, gender, sexuality and disability, with space to record any specific cultural or spiritual needs. Plans clearly documented what support people required with day to day living tasks such as eating meals or with personal care. They gave a good indication of people's daily routine, with instruction to staff unfamiliar with person. They were written in a person-centred way, for example, 'I usually like to get up around 7:00 am, and have a cup of coffee with two sugars,' or 'It's important to be comfortable and

clean", and 'I like to wander, supervise me to ensure safety."

Instructions regarding tasks such as personal care were clear, and allowed people to remain independent with aspects of daily life they could do for themselves. Whilst all the people who lived at Stamford House had care and support needs, the staff recognised that this did not make them totally dependent and people were encouraged to do as much for themselves as they could. One person told us that when they first moved in to the service they had difficulty walking and used a stick to walk only for short distances. They showed us that they were now fully mobile, and told us this was due to the encouragement and support of the staff team who had helped them to regain confidence and ability in their abilities.

Staff maintained daily records for each person. These provided a comprehensive chronology, and gave a flavour of any day to day interactions the person was involved in, their mood and how their needs had been addressed.

Risk assessments and care plans were kept up to date and reviewed monthly, and these noted changes. For example we saw one review reflected changes in the person's general mental health, eating and posture. A full generic review of each person's needs was undertaken on a six-monthly basis. In addition, the registered manager would hold a 'supervision session' with each person who used the service. If a relative was involved in their care they would be invited to attend if the person wanted them to, with records of who was present at the review.

An activity board advertised activities such as pamper sessions, nail painting, reading newspapers, cards, quizzes and 'take out' nights'. Most of the these were conducted on a one to one basis. The activity co-ordinator told us that they used to arrange structured group activities but these were not popular. People who used the service confirmed this. One person said, "Oh no, can't be doing with any activities, I'm bloody lazy!" We had earlier seen the activity coordinator spending some time in conversation with this person, and then brought them some reading material, checking that they had their reading glasses.

Other people told us they were satisfied with the level of activities and stimulation. One said, "There's not always a lot going on, but I'm alright about that, it suits me. I go at my own pace. I can watch telly or sit and chat. I like to watch people come and go", and another said, "They bring in papers to read. I don't get out much, because of my legs, but I've enough to do." The activity coordinator told us their role was to combat isolation. They said, "We have a mishmash of people all with different hobbies and interests. Communication is key; I provide material and just let it flow. No one is ignored and we have time to spend with people." We saw that all staff spent time with the people who lived at Stamford House, encouraging conversation and getting others to join in. Bonds were created and friendships formed. Throughout our inspection we saw people involved in talk and conversation with each other and saw that people had formed friendship groups with one another.

The service had only received one formal complaint since our last inspection, and we saw that this was appropriately recorded with evidence of response, investigation and outcome. All complaints, and concerns, formal and informal, were noted in a 'grumble book' where the senior staff would record any issues of concern raised. This recorded any day to day concerns raised by people who used the service, their relatives or any visitors to the service, action taken to resolve the issue and any lessons learnt from the information gathered.

There was evidence that people's wishes for their end of life care had been considered, and people were given the opportunity to discuss their wishes for how they would like to be supported as they neared death. The care records we looked at indicated that discussions had begun. One care worker we spoke with was

completing a six week course with a local hospice around support for people at the end of their life. They told us that they had learnt much, particularly around dignity and religious needs and what might be important to people. They told us, "It's not just end of life, it's about how people live, and how we need to support them when they are healthy." There were a number of compliment cards and thank you letters. One we looked at said, "Although it was difficult to watch her decline… we never once had to worry that she was not being looked after. We thank you from the bottom of our hearts for the care you gave." Where people had a funeral plan in place this was kept in care records and where appropriate a 'do not attempt resuscitation' form (DNAR) signed by the person's GP was kept at the front of the person's file. A DNAR form is a document issued and signed by a doctor, after consultation with the person and their relatives which advises medical teams not to attempt cardiopulmonary resuscitation

Good

Is the service well-led?

Our findings

At our last inspection we rated the well led section as requires improvement. At this inspection we found that improvements had been made and re-rated this section as good.

It is a requirement under The Health and Social Care Act that the manager of a service like Stamford House is registered with the Care Quality Commission (CQC). The service had a registered manager who had been in post since October 2015. The registered manager was assisted in the running of the home by a deputy manager. The registered manager and the deputy manager worked alternative weekends and both were available out of hours in the event of an emergency. This ensured that there was always managerial oversight of the service. The registered manager told us that the owner of Stamford House was supportive. They said the provider would listen to any requests for assistance or to provide new equipment, and had overseen the ongoing maintenance plan. The registered provider visited the service every two weeks and completed regular audits such as reviews of accidents, or service user finance records to ensure the home maintained a good quality service.

When we asked, staff expressed confidence in the management team. They told us, "We can always approach the managers, they are always there or at the end of a 'phone." They said the registered manager was, "Okay to work with, but she is our manager, and will pull us up where necessary, but in a good way. She encourages us to be better at our job." The registered manager encouraged a team approach, and during our inspection we saw good levels of teamwork and cooperation amongst staff. Staff told us this was the norm, that they recognised individual stresses and helped each other out. One said, "We all get on and work as a team. I've never thought about going elsewhere, it's a family here."

We saw that both the registered manager and deputy were visible and spent time supporting people who used the service. They operated an 'open door' policy and we noticed people who lived at Stamford House felt comfortable to walk into the office. One person told us, "The manager is really good. She looks after us really well and knows what's right for us." Another told us that this was cascaded to the staff. They said, "The staff are fine and know what they're doing, the managers see to that. All are equally good, they are kind and patient. [The registered manager and deputy manager] tell us what's happening, we don't need resident's meetings, if we have anything to say we can always talk to them, and they'll listen." The registered manager met with each person who used the service on a regular basis. Records showed issues discussed included personal needs and any issues affecting the day to day management of their care. This provided each person who used the service with the opportunity to give feedback to the registered manager on the quality of the care and support they received.

There were systems in place to monitor the quality of the service. The registered manager and provider conducted regular audits and checks to look at the quality of care. For example, regular health and safety audits were undertaken to check the safety of the environment and where issues were identified appropriate action was put in place.

We looked at several audits in place such as medication audits, environmental cleanliness, equipment

audits and reviews of accidents and incidents. We saw in some cases that the information gathered through audits could have been used to further develop the service and improve the quality of service provision. For example, audits noted the frequency of falls but did not identify patterns such as where they occurred or the time of day. This information could be used to highlight specific areas or times greater vigilance would be beneficial. We spoke to the registered manager about this and they agreed to use the information available to consider ways of improving the quality of the service.

Staff meetings were held several times each year. We looked at the minutes of the most recent meeting held the month before our inspection, which were displayed on the staff notice board. The meeting was well attended, and issues discussed included discussions around internal security, and the use of CCTV cameras in the home; reminders to staff about the disposal of clinical waste, information about any recent changes to people's care plans and discussion about plans for upcoming parties and visiting entertainers. There was evidence of good discussion and staff involvement.

The service had a range of policies covering all aspects of service delivery, including safeguarding vulnerable adults, whistleblowing, medicine administration and health and safety. All were up to date and in line with current legislation and guidance. We saw the registered manager reported any incidents that affected the running of the service or involved people who used the service in line with our regulations.

It is a legal requirement that each service registered with the CQC displays their current rating. We saw the rating awarded at the last inspection and a summary of the report was on display on the main noticeboard.