Seaham Care Limited

Dr. Ashdown's Stockton Lodge

Inspection report

Seaton Park
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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 took place on 5 April 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting.

The home had a registered manager in place. A registered manager is a person who has registered with 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. The registered manager was not present during our visit however the deputy manager was present and was acting as manager at the time of the inspection.

Dr. Ashdown's Stockton Lodge was last inspected by CQC on 7 April 2014 and was compliant with the regulations in force at the time.

Dr Ashdown's Stockton Lodge provides care for 39 older people. The home is located in the centre of Seaham close to all the towns' amenities and transport links. On the day of our inspection there were 25 people using the service. The home comprised of 39 bedrooms, 19 of which were en-suite, set over three floors. The home was set in its own grounds and facilities included several lounges, dining rooms, communal bathrooms and toilets.

People who used the service and their relatives were complimentary about the standard of care at Dr Ashdown's Stockton Lodge. Without exception, everyone we spoke with told us they were happy with the care they were receiving and described staff as very kind, respectful and caring.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Training records were up to date and staff received supervisions and appraisals.

There were appropriate security measures in place to ensure the safety of the people who used the service and the provider had procedures in place for managing the maintenance of the premises.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia type conditions.

The service was working within the principles of the Mental Capacity Act 2005 and any conditions on authorisations to deprive a person of their liberty were being met.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. Care records contained evidence of consent.

People were protected against the risks associated with the unsafe use and management of medicines.

People had access to food and drink throughout the day and we saw staff supporting people at meal times when required.

The home had a full programme of activities in place for people who used the service.

All the care records we looked at showed people's needs were assessed. Care plans and risk assessments were in place when required and daily records were up to date. Care plans were written in a person centred way and were reviewed regularly.

We saw staff used a range of assessment tools and kept clear records about how care was to be delivered. People who used the service had access to healthcare services and received ongoing healthcare support.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. There were sufficient numbers of staff on duty in order to meet the needs of people using the service.

Staff had completed training in safeguarding of vulnerable adults and knew the different types of abuse and how to report concerns.

The provider had procedures in place for managing the maintenance of the premises.

Is the service effective?

Good

The service was effective.

Staff were properly supported to provide care to people who used the service through a range of mandatory and specialised training and supervision and appraisal.

People had access to food and drink throughout the day and we saw staff supporting people when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia.

Is the service caring?

Good

The service was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their relatives to provide individual personal care.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a person centred way and were reviewed regularly.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff we spoke with told us they felt able to approach the registered manager and felt safe to report concerns.

The provider had policies and procedures in place that took into account guidance and best practice from expert and professional bodies although would benefit from regular review.

Dr. Ashdown's Stockton Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 5 April 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by an adult social care inspector, a specialist advisor in nursing and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had expertise in older people's services.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding and infection control staff. Issues had been raised by commissioners following the outcome of their Quality Banding Assessment in July 2015 relating to staff recruitment checks and the administration of medicines.

During our inspection we spoke with ten people who used the service and five relatives/friends. We also spoke with the deputy manager, four care staff, the activities co-ordinator, maintenance man and a kitchen assistant.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as audits, surveys and policies.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the deputy manager about what was good about their service and any improvements they intended to make.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and supported. A person told us, "Yes I feel safe and I can contact the staff if I have any problems".

Dr. Ashdown's Stockton Lodge comprised of 39 single bedrooms, 19 of which were en-suite.
Overall the communal bathrooms, shower rooms and toilets were clean, spacious and suitable for the people who used the service. They contained appropriate, wall mounted soap and towel dispensers. Grab rails in toilets and bathrooms were secure. All contained easy to clean flooring and tiles. There was also a garden with a patio area. We saw the home was generally clean, well decorated and maintained. It was warm and comfortably furnished. We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

Equipment was in place to meet people's needs including hoists, wheelchairs, walking frames and pressure cushions. Where required we saw evidence that equipment had been serviced in accordance with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We saw windows were fitted with restrictors to reduce the risk of falls and wardrobes in people's bedrooms were secured to walls. Call bells were placed near to people's beds or chairs and were responded to in a timely manner.

We looked at the records for portable appliance testing, emergency lighting, gas safety and electrical installation. All of these were up to date. Hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. This meant the provider had arrangements in place for managing the maintenance of the premises

We looked at the provider's accident reporting policy and procedures, which provided staff with guidance on the reporting of injuries, diseases and dangerous occurrences and the incident notification requirements of CQC. Accidents and incidents were recorded and the registered manager reviewed the information quarterly in order to establish if there were any trends.

We saw a fire emergency plan on each floor which displayed the fire zones in the building. We saw fire drills were undertaken regularly and a fire risk assessment was in place. Weekly fire alarm checks were completed and checks on fire extinguishers were up to date. We looked at a copy of the provider's business emergency contingency plan reviewed 31 March 2016. This provided emergency contact details and identified the support people who used the service would require in the event of an evacuation of the premises. The service had Personal Emergency Evacuation Plans (PEEPs) in place for people who used the service. These included the person's name, assessed needs, details of how much assistance the person would need to safely evacuate the premises and any assistive equipment they required. This meant the provider had arrangements in place for keeping people safe.

We saw a copy of the provider's safeguarding adult's policy dated March 2012, which provided staff with

guidance regarding how to report any allegations of abuse, protect vulnerable adults from abuse and how to address incidents of abuse. We saw that where abuse or potential allegations of abuse had occurred, the manager had followed the correct procedure by informing the local authority, contacting relevant healthcare professionals and notifying CQC. Staff had completed training in safeguarding and the staff we spoke with knew the different types of abuse and how to report concerns. This meant that people were protected from the risk of abuse.

We discussed staffing levels with the deputy manager and looked at staff rotas. The deputy manager told us that the levels of staff provided were based on the dependency needs of residents and any staff absences were covered by existing home staff and regular bank staff. We saw there were five members of staff on a day shift, which comprised of the deputy manager and four care staff. The night shift comprised of three care staff. We observed enough staff on duty for the number of people in the home. A relative told us, "You never have to wait for the staff if you need them."

We looked at the selection and recruitment policy and the recruitment records for three members of staff. We saw that appropriate checks had been undertaken before staff began working at the home. Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of birth certificates and driving licences. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained.

The service had generic risk assessments in place, which contained detailed information on particular hazards and how to manage risks. Examples of these risk assessments included use of lifts, moving and handling, scalds and burns, moving around the home slips/trips and using cleaning products. This meant the service had arrangements in place to protect people from harm or unsafe care.

We looked at the provider's management of medicines policies dated March 2012. The policies covered all key aspects of safe and effective medicines management although would benefit from review. There was also a copy of the British National Formulary, which is a pharmaceutical reference book produced by the British Medical Association and the Royal Pharmaceutical Society of Great Britain, available for staffs reference. The service used medicine supplied by a local pharmacy. A member of staff told us, "It is a good pharmacy service, we have no real problems. There is a dedicated member of staff in the pharmacy who we liaise with and they are very helpful. We have no problems if we need emergency medicine it is obtained immediately." We looked at the medicines administration charts (MAR) for fifteen people and found one omission which meant we could not be assured that person had been given their medicine on that day. We discussed this with the deputy manager who addressed the matter at the time of our inspection.

A signature verification sheet to identify staff initials who were approved to administer medicine was available at the front of each Medication Administration Chart (MAR) chart file. Clear guidance was in place to ensure staff were aware of the circumstances to administer "as necessary" medicine. People's photographs and allergy information was stated on MAR charts in addition to being included within their care plans. A medicine review schedule was maintained that identified the last and next planned review date of medicines. There were clear procedures in place regarding the ordering, supply and reconciliation of medicine. Appropriate arrangements were in place for the administration and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. Medicines were stored securely and medicines requiring storage within a locked fridge were appropriately stored with the fridge temperatures monitored daily. We saw that medicine audits were up to date and demonstrated a high level of compliance. Medicine administration was observed to be appropriate and staff demonstrated patience in encouraging people

during the administration process. Staff who administered medicines were trained and their competency was observed and recorded by senior staff.

Good

Is the service effective?

Our findings

People who lived at Dr. Ashdown's Stockton Lodge received care and support from trained and supported staff. All the people and relatives we spoke with were confident the staff knew what they were doing when they were caring for them. A relative told us, "The staff are really effective in caring for my family member, I have peace of mind that they are safe and secure", "I think they look after us all well", "I am fine" and "If there are any problems the staff let us know straight away.

We looked at staff training records and we saw that staff had received an induction and we saw that mandatory training was up to date. Mandatory training included moving and handling, fire safety and drills, safeguarding, risk assessment, infection control, health and safety, medicines, control of substances hazardous to health (COSHH) and first aid. Records showed that most staff had completed either a Level 2 or 3 National Vocational Qualification in Care or a Level 2 in Health and Social Care. In addition staff had completed more specialised training, in for example, end of life, palliative care, diabetes, dignity, equality and diversity, mental health, dementia awareness, challenging behaviour and non-abusive psychological and physical intervention (NAPPI).

Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. This meant that staff were properly supported to provide care to people who used the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service 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 looked at records and discussed DoLS with the deputy manager, who told us that there were DoLS in place and in the process of being applied for. Consent forms and mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. Staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We found the provider was following the requirements in the DoLS.

The care records we looked at included a Do Not Resuscitate (DNR) form which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date and showed the people who used the service had been involved in the decision making process.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. We saw menus displayed in the dining room which detailed the meals and snacks available throughout the day. We observed staff chatting with people who used the service and offering them a choice of food and drink. The atmosphere was not rushed. Tea, coffee, fruit juices, biscuits, scones and cake were served several times during the day. Fruit was also made available and cut into easily managed pieces. We looked at records and spoke with the kitchen assistant who told us about people's special dietary needs and preferences. From the records we looked at, we saw all staff had completed training in food hygiene and several staff had completed more specialised training in focus on food, food allergy, diet, nutrition and hydration.

A person who used the service told us they had "put on a stone since admission" and several others told us how they enjoyed 'themed meals' and fun activities including pie and pea suppers, Christmas lunch, World War Two recipes and a Halloween party where the carers participate and dress up.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including chiropodist, optician, advanced nurse practitioner, dietician, GPs, specialist memory nurse, district nurses, dentist, community psychiatric nurse and occupational therapist. This meant the service ensured people's wider healthcare needs were being met through partnership working.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at Dr. Ashdown's Stockton Lodge. Without exception, everyone we spoke with told us they were happy with the care they were receiving and described staff as very kind and compassionate. People and their relatives told us, "It's a real home from home for her", "It's a busy home but staff always have time for you. I'm very satisfied" and "I like it here."

People we saw were well presented and looked comfortable. We saw staff talking to people in a polite and respectful manner. Staff interacted with people at every opportunity, for example encouraging them to engage in conversation or asking people if they wanted help when they passed them in the lounges or in their bedrooms.

We observed staff interacting with people in a caring manner and supporting people to maintain their independence. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. This meant that staff treated people with dignity and respect.

Staff demonstrated they understood what care people needed to keep them safe and comfortable. We observed a member of staff safely aiding a resident to their feet from a seated position with the use of a standaid in a lounge. Throughout the transfer the staff member helped, calmly, the person to stand and constantly reassured the person.

We saw the bedrooms were individualised, some with people's own furniture and personal possessions. The service provided a small furnished "quiet area" at the rear of one of the dining rooms where visitors and relatives could meet with people who used the service.
People and their relatives told us the home welcomed visitors at anytime of the day. They told us, "We are always made welcome and offered refreshments." A member of staff told us, "It's a homely home."

A member of staff was available at all times throughout the day in most areas of the home. Staff focussed on the people's needs. We observed staff spoke with people by their chosen name with warmth and professional familiarity. Jokes were exchanged and light hearted banter. We saw a member of staff explained to a person with a sight impairment what was on their plate and where the items were. We observed another member of staff explaining to a person how important it was for them to drink plenty of fluids and how, when the person had expressed a preference for a drink of 'coca cola', a member of kitchen staff offered to go to the adjacent supermarket to buy some for them.

The care records we looked at showed staff had involved people who used the service and their relatives in developing and reviewing care plans and assessments. A relative told us, "[Name] is treated as a person and the whole family are involved."

People were provided with information about the service in a 'service user guide' which contained information about health and safety, facilities, meals, services, staff, rights, advocacy, safeguarding,

complaints and contact details for the local authority and CQC. Information for people and their relatives was prominently displayed on notice boards throughout the home including, for example, safeguarding, advocacy, independent mental capacity advocate (IMCA), Flu, Alzheimer's memory loss and a Seaham Town Guide.

Good

Is the service responsive?

Our findings

The service was responsive. We looked at care records for three people who used the service. All residents had their needs assessed and there was evidence of regular review, updating and evaluation.

The home used a standardised framework for care planning with care plans person centred to reflect identified need. This was evidenced across a range of care plans including safe environment, personal care and hygiene, elimination, nutrition and hydration, breathing, mobility, sleep, death and dying, skin integrity, socialisation, sexuality, communication, pain and falls.

The care plans had been developed from a person centred perspective. All care plans examined included a document called 'My person centered care plan' and this document provided insight into each person's likes and dislikes. This was a valuable resource in supporting an individualised approach. Each care plan had a risk assessment in place. Risk assessments contained control measures and recommendations from professionals. This meant risks were identified and minimised to keep people safe.

All of the care plans we looked at contained a resident's photograph and all recorded their allergy status. We saw staff used a range of assessment and monitoring tools and kept clear records about how care was to be delivered for example, malnutrition universal screening tool (MUST) which is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition and waterlow which assessed the risk of a person developing a pressure ulcer. Body Maps were used where they had been deemed necessary to record physical injury.

The service employed an activities co-ordinator. We saw the daily activities plan on the notice board. Activities within the home included board games, arts and crafts, dominoes, bingo, softball darts, quits, scrabble, hairdresser, chair exercises, baking, watching films, card games, knitting, monthly church services, sing a longs, pampering sessions, 'Play your cards right' with two teams and 'Bullseye'. On the morning of our visit we saw a group of people participated in a sing-along session which included World War One songs, Elvis Presley and Neil Sedaka. Some people played tambourines, a triangle and maracas while others sang or clapped along. Staff supported those people who required assistance. On the afternoon we observed two people sitting together to play dominoes in a dining room while several others enjoyed a quiz in a lounge.

People who used the service told us, "Darts and dominoes are great." Several people told us that "they would like to knit or crochet". The activities co-ordinator told us how she had asked family and friends for wool and intended to start a knitting and crochet group for interested residents, family members and possibly the local community. Staff told us people could participate in gardening by, for example, potting up bulbs and bedding plants and growing tomatoes or strawberries in pots or hanging baskets. The activities co-ordinator told us "Colouring in" has been popular recently as a form of "mindfulness" to promote calm and reduce agitation in people living with dementia. A reading club had been started with the activities co-ordinator reading aloud to a group with active participation from people who used the service. The activities co-ordinator told us how she was exploring the use of audiobooks and items that the Royal National Institute of Blind People (RNIB) may be able to provide for people with sight impairment. This meant people

had access to activities that were important and relevant to them.

People were encouraged and supported to maintain their relationships with their friends and relatives. People and their friends told us, "We are made welcome and [Name] likes it here" and "My pet dog comes to visit." This meant people were protected from social isolation.

All the people we spoke with told us they could make choices about how they wanted to receive the care they needed at Dr. Ashdown's Stockton Lodge. They told us they were able to go to bed and get up at whatever time they wished, choose what clothes to wear, decide on their lunch for that day and what activities to participate in. One person told us they preferred to receive personal care from a male carer and staff told us this was arranged.

We saw a copy of the complaints policy on display in the reception area. The people and their relatives we spoke with were aware of the complaints process. They told us, "I have never had to make any complaints but would be confident to do so and I know they would be sorted", "I would know to go to the manager if needed", "We have never needed to make a complaint but we know it would be dealt with if there was one", "I would speak to the staff if I had a concern" and "I have never had to make a complaint but would feel free to do so." We saw that complaints were recorded, investigated and the complainant informed of the outcome including the details of any action taken. The last recorded complaint was dated 15 March 2015. This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place however we were informed that they were on short term absence. A registered manager is a person who has registered with CQC to manage the service. The registered manager had been registered with CQC since 17 October 2013. The deputy manager was acting as manager in the interim. We discussed the management arrangements with the deputy manager and we found the arrangements to be satisfactory and supportive of the deputy manager. The CQC registration certificate was prominently displayed in the home's entrance.

Staff we spoke with were clear about their role and responsibility. They told us they felt supported in their role and were able to approach the registered manager or to report concerns. Staff told us, "I am happy working here we have a good team" and "I am proud to work here."

We looked at what the registered manager did to check the quality of the service. We saw a range of audits were undertaken including health and safety, infection control, the kitchen and hand hygiene. All of these were up to date and included action plans for any identified issues.
The home had been awarded a "5 Very Good" Food Hygiene Rating by the Food Standards Agency on 17 February 2015 and had received a certificate from NHS Durham and Darlington in recognition for focusing on undernutrition.

We looked at what the registered manager did to seek people's views about the service. There was a 'comments book' in reception and people using the service, their relatives, visitors and stakeholders were asked about the quality of the service. Comments recorded were positive. We saw resident/relatives meetings were held on the first day of each month. The record of the meeting held in February 2016 discussed meals and activities. The meeting held in March introduced the new activities coordinator to the service and discussed people's activity preferences.

We saw sixteen completed questionnaires from a 'satisfaction survey'. Questionnaires were completed by people who used the service, their relatives, care managers and visiting professionals. Questions gathered people's views on the quality of the service, friendliness of staff, cleanliness, décor and ambience, response to phone calls and complaints, meals and the provision of information. Most responses were dated March 2016 and all were very positive.

Staff meetings were held regularly. We saw a record of a staff meeting dated 16 February 2016. Discussion items included sickness/absence, the local authority's quality banding assessment and infection control. Ten staff attended. We also saw a completed 'staff satisfaction survey' dated August 2015. Responses were positive. This meant that the provider gathered information about the quality of the service from a variety of sources and had systems in place to promote continuous improvement.

The service had policies and procedures in place dated that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions. There was no evidence to demonstrate the policies had been reviewed since 2012. The deputy manager told us, "Policies were

currently being reviewed by the registered provider."

On the day of our visit we saw personal information about each person's care and treatment was not kept sufficiently secure on the staff workstation in the entrance to the home. We discussed this matter with the deputy manager who addressed it at the time of our inspection. Records were maintained and used in accordance with the Data Protection Act.