Mr & Mrs R Cowen

Stonehaven Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 April 2017 and was unannounced. The home provides accommodation for up to 27 people, including some people living with dementia care needs. There were 11 people living at the home when we visited. The home was based on two floors connected by a passenger lift; there was a choice of communal spaces where people were able to socialise; most bedrooms had en-suite facilities.

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

At our last inspection, in April 2016, we identified breaches of five regulations. People did not always receive personalised care that met their needs; people were not always treated with consideration; staff did not follow legislation designed to protect people's rights; some areas of the home were not clean and smelt of urine; and quality assurance systems were not effective. We took enforcement action and imposed a condition on the providers' registration to prevent them from admitting new people to the home without written permission from CQC.

At this inspection, we found action had been taken and improvements made. No breaches of regulations were identified, although some areas still required further improvement.

We found staff did not always follow appropriate infection control procedures; they did not always wear protective clothing when handling soiled clothing or wash their hands afterwards. However, the home was significantly cleaner than at our last inspection and smelt fresh.

Essential safety checks of equipment used to support people to move had not been completed, although these were done following the inspection. Staff did not always apply the brakes to wheelchairs when supporting people to transfer to them; this put them at risk of falling. Other risks to people, however, were managed appropriately.

Medicines were managed safely, although guidance was not followed to help ensure one person received their 'as required' medicine when needed.

Staff received appropriate support and training. Some staff did not always apply their training in practice when supporting people living with dementia, although other staff demonstrated a sound understanding of how to meet people's dementia care needs.

People were complimentary about the food. Their dietary needs were met and they received appropriate support to eat. However, staff did not always maintain a suitable atmosphere in the dining room that encouraged people to eat well.

Improvements had been made to the environment. These supported the needs of people living with dementia and helped them navigate around the home. However, the call bell system was loud and intrusive and had the potential to impact adversely on people.

There were enough staff to meet people's needs. Appropriate recruitment procedures were followed. People were protected from the risk of abuse and staff had received safeguarding training.

Staff followed legislation designed to protect people's right. They sought consent from people and acted in their best interests.

Staff had built positive relationships with people and treated them with kindness and compassion. They protected people's privacy and dignity, involved them in decisions about their care and encouraged them to remain as independent as possible.

People received personalised care from staff who understood and met their needs. Staff were led by people's wishes and supported them to make as many choices as possible. People were supported to access healthcare services when needed.

Care plans contained information and guidance to staff to help ensure people received consistent care. They were reviewed regularly and staff responded appropriately when people's needs changed.

People had access to a range of activities to meet their social needs. The registered manager sought and acted on feedback from people and people knew how to raise concerns.

People were happy living at Stonehaven and had confidence in the management. Staff understood their roles, worked well as a team and were encouraged to make suggestions for improvement.

There was an open and transparent culture. The registered manager had engaged with a health and social care specialist from the Clinical Commissioning Group to enhance the service. Positive links had been developed with the community to the benefit of people.

An appropriate quality assurance system had been developed to help ensure the service remained compliant with the regulations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always follow appropriate procedures when handling dirty clothing. However, improvements had been made to the cleanliness of the home.

Staff did not always ensure the brakes on wheelchairs were applied when supporting people to transfer into them. However, other individual and environmental risks to people were managed appropriately and in the least restrictive way.

People were protected from the risk of abuse. There were appropriate arrangements in place for obtaining, storing, administering and disposing of medicines.

There were enough staff to support people at all times. Appropriate recruitment procedures were followed to help ensure only suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received appropriate training and support for their role. Some staff members did not always apply their training in practice, although other staff members demonstrated skill and competence.

People's nutritional needs were met and they received support to eat and drink enough.

The environment of the home had been improved to make it more supportive of people living with dementia.

Staff followed legislation designed to protect people's rights and freedom. They supported people to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion. Staff interacted positively and built supportive relationships.

Staff protected people's privacy at all times and encouraged them to remain as independent as possible.

People and their families, where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who understood their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. They had access to a range of meaningful activities.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Good

The service was well-led.

People were happy living at Stonehaven and had confidence in the management. There was a clear management structure in place. Staff understood their roles and worked well as a team.

Staff were encouraged to make suggestions for improvement and were listened to. The providers had a clear set of values that were understood by staff.

There was an open and transparent culture and working relationships with external professionals had improved. Links with the community had been developed to the benefit of people.

A comprehensive quality assurance system was in place to help ensure compliance with the regulations.

Stonehaven Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the providers were 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 3 April 2017 and was unannounced. It was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the providers completed a Provider Information Return (PIR). This is a form that asks the providers to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, together with previous inspection reports and notifications we had been sent by the providers. A notification is information about important events which the service is required to send us by law.

We spoke with seven people living at the home and three visiting family members. We also spoke with the registered manager, the deputy care manager and four care staff. We also obtained feedback from the local authority's safeguarding and commissioning teams.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in April 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as some areas of the home were not clean and other areas smelt strongly of urine. At this inspection, we found action had been taken and there was no longer a breach of this regulation. All areas of the home were significantly cleaner and smelt fresh; and damage to a toilet wall and the flooring in the laundry had been repaired since the last inspection. One person told us, "It's nice and clean everywhere", and another said they had "no worries" about the cleanliness of the home.

However, further improvement was still required as staff did not always follow appropriate infection control procedures. We observed a staff member carry a bundle of dirty clothes from a person's room to the laundry for washing. They held the clothes close to their chest, but did not wear disposable gloves or a disposable apron to prevent their uniform becoming contaminated. When they arrived in the laundry, they put the clothes on the floor and another staff member then helped them sort the clothes into the relevant laundry bins. When they had finished doing this, the first staff member left the laundry without washing their hands and went about their duties supporting people. The second staff member, however, did wash their hands. Guidance issued from the Department of Health specifies that disposable aprons and gloves should be worn when handling laundry; that laundry should not be sorted on the floor due to the risk of contamination; and that staff should wash their hands afterwards. We discussed the handling of laundry with the registered manager who told us they would not always expect staff to always wear disposable gloves and aprons as it depended on the circumstances, but said staff got through "hundreds of boxes" of disposable gloves".

At other times, staff followed appropriate infection control procedures. For example, they used personal protective equipment when needed and washed their hands before serving drinks and meals. The providers had a suitable infection control policy in place; they had conducted infection control risk assessments and an annual statement of infection control. This is used to detail any outbreaks of infection, staff training and audits of infection control that had been completed. Staff had received training in infection control and completed cleaning check sheets stating that cleaning had been undertaken in accordance with cleaning schedules.

Safety checks of equipment used to support people to move, including hoists and a bath chair, had not been completed as required. Health and safety regulations require six monthly checks of such equipment, but we saw checks had not been completed for over a year. We discussed this with the registered manager, who told us they were in the process of changing the external contractor who was qualified to conduct the checks. Following the inspection, the registered manager made arrangements for the checks to be completed and sent us updated certificates confirming the equipment was safe to use.

Other environmental risks were managed appropriately. Regular checks of gas and electrical equipment were conducted. The water temperature of sinks was regulated and checked on a monthly basis. There was a process in place to check fire safety equipment regularly and staff had received fire safety training. Personal emergency evacuation plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were knowledgeable

about people's specific plans and the fire procedures for the home; they had also been trained to administer first aid.

Staff had assessed the risks associated with providing care to each person; these were recorded along with actions identified to reduce those risks. For example, people who were at risk of falling had risk assessments in place in respect of the support staff should offer to help them mobilise safely. During the inspection we observed staff monitored people and, in most cases, offered support in line with their risk assessments. However, we observed two instances where staff supported people to transfer from a chair to a wheelchair when the brakes of the wheelchair had not been applied. One person was very rigid and as they were supported into the wheelchair, it started to move backwards and they were at risk of falling. We checked the brakes on the wheelchairs and saw they were working, but they had not been applied.

The risk of people developing pressure injuries had been assessed using a nationally recognised tool and appropriate action was taken when people were identified as at high risk. For example, they were provided with special pressure relieving, cushions and mattresses; the mattresses were set correctly, according to the person's weight, and a clear process was in place to help ensure they remained at the right setting.

Other people were supported in a way that respected their independence. Some people chose to self-mobilise around the home. Staff allowed them the freedom to do this, while monitoring their movements and giving appropriate support. For example, when one person wanted to get up and walk around the home, the staff member encouraged them to stand independently and gave clear instructions on how they could best do this in a way the person could understand. At other times, staff gave advice to people in passing, such as "don't forget your [walking] frame" or "be careful of the stairs".

When people experienced falls, their risk assessments were reviewed. One person had fallen out of bed and we saw additional precautions had been considered, in conjunction with the person's GP, to identify the least restrictive option. A protective mat had been placed beside their bed, together with a sensor to alert staff when the person moved to an unsafe position. The area surrounding their bed had also been cleared of potential hazards.

People told us they felt safe at the home. One person said, "I feel quite safe. I have checked their procedures for locking doors at night and I feel safe knowing that." Another person told us, "I feel very safe in here"; and a further person said, "I don't think I have ever had any worries. If I did I would let [a particular staff member] know". A family member told us they had "no worries at all about safety".

Staff had the necessary knowledge to enable them to respond appropriately to concerns about people's safety and were aware of people who were at risk of abuse. All staff had received safeguarding training; they knew how to raise concerns and were confident that managers would take appropriate action. One staff member told us, "I would report concerns to the manager, I would be confident they would respond". Another staff member said, "I would report my concerns to the deputy care manager or manager. If I needed to I would go directly to the local safeguarding team or CQC."

People were supported to receive their medicines safely. There were appropriate arrangements in place for obtaining, storing, administering and disposing of medicines. One person told us, "I'm very happy with my medication, I take lots of different pills. I can also get pain relief tablets if I need them." We saw medicines were administered in a safe way, by staff who were suitably trained and competent. The staff member gained verbal consent from the person, explained what the medicine was and what it was for; they then remained with the person to ensure the medicine had been swallowed.

Medicines administration records (MAR) were completed correctly. On viewing the MAR charts, no gaps were identified; this indicated that people had received their oral medicines when needed. The MAR charts used to record the application of topical creams were also fully completed, with the exception of one person's chart which contained unexplained gaps. A senior staff member thought the person had probably declined to receive the creams on these days, but acknowledged that this should have been recorded. There was an effective process in place to help ensure topical creams were not used beyond their 'use by' date.

Comprehensive information was available to guide staff when administering most 'as required' (PRN) medicines, such as pain relief and sedatives, to help ensure they were given in a consistent way. However, records showed that one person did not always receive a PRN medicine for anxiety when needed. The guidance stated it should be given half an hour before bathing. Records showed it had not been given at these times, but had been given at other times, when they had become "aggressive and shouting at staff and residents". There was no information or risk assessment in place to guide staff about what actions should be taken when the person behaved in this way. We discussed this with a senior member of staff, who undertook to review the use of this PRN medicine and develop a risk assessment and care plan to help ensure the person was supported appropriately. Where people were prescribed PRN pain medicine, this was supported by a pain assessment tool. Clear information was on the PRN chart stating when and why the medicine had been given, together with the outcome.

For one person, an appropriate procedure was in place and followed for the covert administration of their medicines. This is when essential medicines are hidden in small amounts of food or drink and given to a person. The procedures protected the person's legal rights and all relevant people, including the person's GP and relative had been involved in the decision to administer medicines in this way. Staff followed best practice guidance by offering the medicines to the person in an open way first and only reverting to covert administration if they declined to take them.

There were enough staff to meet people's care needs and provide a supportive presence in communal areas. Staff frequently visited people who chose to remain in their room and responded promptly when they pressed their call bells, which were always in reach. One person told us, "Staff turn up on time when care is due or when I need them." A family member confirmed this and added, "Every time someone [staff] walks past they call in and talk to [my relative]." We saw staff had time to sit with people and provide unhurried care in a relaxed way. The registered manager told us staffing levels were based on a 'dependency tool' in conjunction with their observations and feedback from people and staff. Absence and sickness were covered by permanent staff working additional hours, which meant people were cared for by staff who knew them and understood their needs.

The providers had safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these procedures were followed before they started working with people.

Requires Improvement

Is the service effective?

Our findings

Most staff had the skills and competence to enable them to support people effectively. A person told us, "I think they [staff] have the right skills; otherwise I wouldn't stay here." Another person said, "They [staff] take good care of me; they look after me very well." A family member confirmed this and said, "Staff seem to have the right skills, no problems."

All staff completed the providers' 'mandatory training', which included safeguarding, moving and handling, infection control and fire safety. One staff member told us, "Training is continuous; we are always being offered training." Staff told us they had access to, or could request, other training that focused on the specific needs of people using the service; for example, some had completed end of life training at a local hospice. Staff were also encouraged to obtain vocational qualifications relevant to their role, including a senior staff member who was being supported to obtain a management qualification. The registered manager was also providing additional training to staff each week to help them understand and contribute to the care planning process.

When we spoke with staff, they showed an understanding of how to support people living with dementia; however, we saw they did not always apply this knowledge in practice. For example, one person did not want to sit down to eat at lunchtime, but chose to walk around the lounge and dining room carrying their knife and fork. The staff member told us this was "dangerous" and proceeded to take the cutlery from the person. However, they did not do this in a safe or supportive way; they held the person's arm firmly with one hand, while gripping the cutlery with their other hand, saying, "Can I have those please? You can't have a knife". Eventually, the person let go of the cutlery and the staff member took it away. The interaction caused the person to become angry and they swore at the staff member. The staff member had not tried to use distraction or diversion techniques to persuade the person to give up the cutlery voluntarily or to return to their meal. By holding the person's arm so firmly, they risked damaging the person's skin, which was fragile.

Another person started to become anxious and increasingly vocal at lunchtime. Another staff member tried to reassure the person, but this was limited to repeating their name over and over again, which did not help calm them. The staff member did not explore whether the person may have had enough to eat, may have been uncomfortable or may have wanted to move from the dining room. A further person in the dining room became anxious because they could not understand why they could not see properly. Although a staff member got the person another pair of glasses, this did not provide any reassurance and the person continued to ask why they could not see properly. The anxiety of these people unsettled other people in the dining room, who also became restless.

On another occasion, a staff member did not support a person to re-position in an appropriate way. The person was leaning forward in their chair and at risk of falling; without any explanation or warning, the staff member moved the person back into chair, saying abruptly: "You sit back."

However, other staff demonstrated a sound understanding of the training they had received and how to apply it, including when supporting people living with dementia. For example, when a person needed to

change their clothes, following an accident, a staff member used simple language to explain that they wanted to help the person to the bathroom to change. They directed the person in a supportive and patient way without fuss, which helped them remain calm. When staff used hoists to support people to transfer, we saw they operated in pairs, with one staff member supporting the person's head and the other protecting the person's feet and legs. They provided appropriate reassurance and explained what they were doing at each stage. A family member confirmed that staff were always "very careful" when supporting their relative in the hoist.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This varied in length, depending on the staff member's previous experience and aptitude. It included completion of a training programme that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Following this, they spent a period of time working alongside a more experienced member of staff while their competence was assessed.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for the manager to meet with staff, discuss their training needs, identify any concerns, and offer support. In addition, staff who had worked at the home for over a year received an annual appraisal to assess their performance. A staff member told us, "Once a month, I sit down with [the registered manager] and see how it's going, any training or changes I need."

People were complimentary about the food and their dietary needs were met. They were offered a range of options for breakfast, including a cooked breakfasts. At lunchtime, people were given a choice of two main meals and two desserts; they also had access to snacks throughout the day and night, if needed and care records confirmed these had been provided. Information about people's food preferences, likes and dislikes was recorded and had been used to develop nutritional care plans for people. A range of hot and cold drinks was provided and we heard staff encouraging people to drink throughout the day.

When people struggled to eat independently staff were supportive, and offered assistance. One person was provided with a spoon and staff offered to cut up other people's food. If people declined their meal, or ate very little, alternatives were offered. Some people were at risk of not eating or drinking enough, so staff used food charts to monitor their intake and we saw these were completed fully. People were also weighed regularly to help identify unplanned weight loss; when this occurred, staff took appropriate action, including referring people to their GP or to speech and language therapists; they also provided people with high calorie drinks, where needed.

The environment had been improved since the last inspection. Lighting levels were generally better, although an area of the lounge was still not well lit. Toilet and bathroom doors had been painted in bright colours to attract people's attention and large signs were displayed to help people navigate their way around the home. We heard people asking staff for support to use the bathroom, but when they then saw the signs, they chose to go on their own which helped support their dignity and independence. One person told us they appreciated that there was also "a quiet room away from the television". However, the volume and pitch of the call bell system, which was loud and intrusive throughout the home, had the potential to adversely affect people living with dementia as it caused some of them to wince when it sounded. We discussed this with the registered manager who agreed to consider ways of making the system less intrusive.

At our last inspection, in April 2016, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff were not following the Mental Capacity Act 2005 (MCA).

At this inspection, we found action had been taken. There was no longer a breach of this regulation and people's rights were protected.

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that where people lacked capacity to make decisions, in all but one case, staff had completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines and the use of equipment to monitor their movements. For one person, MCA assessments and best interests decisions had not been recorded; a senior staff member told us they were planning to complete the necessary documents in the week following our inspection.

Staff sought consent from people before providing care and support. One person told us, "[Staff are] very good; they listen to what I want, always asking me if they could do this or that." We heard a person living with dementia being consulted before staff carried out personal care. The staff member was aware of the person's limited verbal communication skills, so took their lead from their facial expressions and other non-verbal cues. Staff had clearly documented in care records where they had acted in people's best interests; for example, when providing personal care to a person to help maintain their skin integrity, an entry stated, "[Continence] pad changed in night for her best interests."

One person had capacity to make decisions about their care; they had signed their care plan to indicate their agreement with it and, after discussions with staff, had agreed to follow a specific diet to support them with their weight.

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 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 found the registered manager was following the necessary requirements. DoLS authorisations had been approved where needed and renewal applications had been submitted in good time. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. A community nurse told us they visited two people at the home regularly for treatment of leg ulcers and were given appropriate access.

Good

Is the service caring?

Our findings

At our last inspection, in April 2016, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not always treated with consideration. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

People told us they were cared for with kindness and compassion. Comments from people included: "Staff are all very nice and treat me well"; "Oh yes, very caring. I get cared for well"; and "I'm happy that people care for me". Family members echoed these comments; for example, one told us, "I'm Impressed with how much they [staff] seem to care, impressed with how much they do"; and another said, "When you see them [staff] interacting, they seem very caring."

Staff had built positive relationships with people. They spoke about people warmly and demonstrated a detailed knowledge of them as individuals. One staff member told us, "I feel connected to the people and have got to know them really well." Another said, "I want people to have a really good quality of life." A person told us, "Staff will sit down and have a chat." This was confirmed by another person, who described staff as "good listeners". Staff were able to tell us about people's life histories and their backgrounds. For example, one person was from a large family and enjoyed interacting with dementia dolls that had been provided. A staff member sat with the person and talked about the dolls; when the person asked where another of her "babies" was, the staff member fetched another doll which reassured the person and clearly made them happy. Another person liked to continually sing a particular line from a well-known song and staff sung this with them, especially at times when the person was prone to becoming anxious.

Most interactions we observed between people and staff were positive. Staff used people's preferred names and approached them in a friendly and relaxed manner, constantly checking with people that they were feeling alright and giving them reassurance. When supporting people to move, on all but one occasion, staff gave clear instructions in a patient and supportive way and praised people for the effort they made. As one person was supported to walk from their room to the dining room, they were heard laughing and joking with the staff member, who clearly had a good rapport with the person.

When a person who struggled to express themselves verbally became agitated, a staff member sat with them, held their hand and talked to them. The person became calm, visibly relaxed and smiled at the staff member. Another person became restless and wanted to walk around the home; a staff member accompanied the person and engaged them in meaningful conversation as they walked. When another staff member came across them in a corridor, they greeted the person warmly and gently rubbed their back to provide additional reassurance.

Staff encouraged people to remain as independent as possible within their abilities. A staff member described how they would support a person who liked to walk around the home independently. They said, "I would make sure they have their frame when walking around and that there is nothing in their way that could cause them an injury." The person confirmed this when they said, "I can get around on my frame; [staff] keep an eye out but I'm never told I can't do things." Another staff member told us, "I will talk to

people about things they enjoy and try to help people to remain as independent as possible by giving them the opportunity to do things themselves." Information in people's care plans also encouraged staff to support people's independence. Comments included: "Encourage [the person] to do as much as possible for themselves."

People's privacy and dignity were usually protected. A person told us, "Staff knock on my door and respect my privacy" Another person said, "Generally [staff] knock on my door, but some do forget sometimes." During the inspection, we saw staff took care to make sure toilet and bathroom doors were closed when they were in use. They described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. When staff supported a person to move using the hoist, they covered the person's legs with a blanket to protect their modesty.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Reviews of care plans included details of family members who had been consulted, in addition to the person. One person said, "We do have a chat about my care from time to time." This was confirmed by a family member who told us, "I see the care plans once a year. If they need updating, they [staff] see me about it anytime." Another family member described how they and the person had been involved in discussing the person's future wishes.

Good

Is the service responsive?

Our findings

At our last inspection, in April 2016, we identified a breach of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as care and support were not always provided in a personalised way that met people's needs. At this inspection, we found appropriate action had been taken and there was no longer a breach of this regulation.

People received personalised care from staff who understood and met their needs. One person told us, "[I now get] consistent care; the best since I've been here." Another person said, "[Staff] know what I want and need." All family members we spoke with were positive about the way care and support was delivered to their relatives.

People had their needs assessed before they moved to the home. Information was sought from the person, their relatives and other professionals involved in their care. Care plans were then developed and reviewed on a monthly basis so staff had access to up to date guidance about how they should meet people's current needs. The care plans were centred on the needs of each person, detailing people's normal daily routines, their backgrounds, hobbies, interests and personal preferences. In addition, on the back of people's bedroom doors was a summary of the person and their needs, as a reminder to staff.

Staff were clear that they were led by people's individual wishes and accommodated them wherever possible. They demonstrated a good awareness of the individual support needs of each person living at Stonehaven. For example, they knew that one person was always tired the day following a visit by a close friend and would need to be supported in their room on these days. They knew that another person liked to be coaxed out of their room at lunchtime to socialise with other people and we saw them doing this. The registered manager told us, "The light has switched on [for staff] about the personalisation of care. We've worked a lot around morning routines, for example. It's based on them and how they want to live their lives." Records of the daily care provided confirmed that people had been supported in accordance with their identified needs.

Bath records confirmed that people had received baths according to their individual wishes; some people had received two or three baths in the previous week, while others had had one. One person who had previously been resistant to receiving personal care was now receiving baths regularly from a particular member of staff they trusted. The staff member told us, "I am the only one who can [persuade the person to have a bath] and she has them weekly now."

Staff monitored people's health and well-being; they were responsive to any changes and communicated concerns to one another through the use of a 'handover book' and a meeting at the start of each shift. For example, the handover book noted when people had not slept well, when they had been agitated or when they were showing the first signs of developing pressure injuries. Care records highlighted when people had been unwell or were presenting differently. For example, one person had started to experience falls in their bedroom; they had been offered, and accepted, a downstairs room with a different type of mattress and this had reduced the frequency of their falls.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. Entries in people's care plans confirmed that staff respected people's choices; for example, one said, "[The person] chose to have their breakfast in their room." One person told us, "[Staff] listen to what you want and do it." We saw one person was due to have a bath on the afternoon of our inspection, but told staff they did not want it as they were expecting a visitor. The staff member immediately arranged for them to have their bath later that evening instead. At lunchtime, people were given the option of wearing clothing protectors, which some chose to wear and some didn't.

People told us that they had the opportunity to take part in a range of activities. These included exercises to music, bingo, quizzes, indoor netball and crafts. One person said, "I love doing embroidery and knitting; I can carry on with that here." Another said, "I like sitting in our chairs and doing the exercises"; and a further person told us they had "been down to the beach for a cup of tea". A family member added, "There's quite a bit going on; [people] play games, quizzes, bingo, trips out." During the inspection, we saw people taking part in a word games and watching films. One staff member was a trained nail technician and spent time providing nail care to people who enjoyed being pampered. A person had a reminiscence book, containing photographs from their past, and staff spent time talking to them about the pictures. The home had a dedicated activities coordinator who visited four afternoons each week to arrange and manage activities. When they were not available, activities were run by care staff, in line with an activity timetable displayed in the lounge. People's care plans included an activities record, which highlighted what had been offered and the person's involvement with activities.

The registered manager sought and acted on feedback from people through the use of survey questionnaires and meetings with people. Responses from the latest surveys showed people were satisfied with the care and support being provided. One response indicated that people were not always offered snacks in the evening and we saw the registered manager had raised this with staff and directed them to ensure snacks were always provided. The registered manager told us they had stopped using table cloths in the dining room, but, following comments from relatives, these had been reintroduced. We confirmed this when we visited the dining room.

People told us they would complain if necessary and were confident that any issues would be addressed. Information about how to complain was clearly displayed in the entrance hall, including how to contact external bodies for additional support. One person told us, "I complained to the manager that the light in the lounge was too dim for me to see to read. She went straight out and bought a reading lamp for me." Another person said, "If ever I have a complaint, I talk to [a senior staff member]; she gets things done."

Good

Is the service well-led?

Our findings

At our last inspection, in April 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as effective systems were not in place to maintain compliance with the fundamental standards of quality and safety. At this inspection, we found appropriate action had been taken and no breaches of regulation were identified. The registered manager told us they had particularly focused on improving the recording of care delivered by staff and our observations confirmed that the accuracy and quality of record keeping had improved significantly since the last inspection.

People were happy living at the home and said they had confidence in the management. Comments from people included: "I do like living here. I would not want to live anywhere else"; "I'm quite happy here, there's a good atmosphere"; and "Staff get on well with each other. It's a nice place and a good atmosphere".

There was a clear management structure in place. This comprised of the providers, the registered manager, the deputy care manager and senior care staff. Each had specific responsibilities and understood their roles. During the inspection, we saw and heard the deputy care manager providing clear direction and support for staff. Staff were organised and worked well as a team. A staff member told us, "Everyone knows what they are doing. We have a handover [meeting] and are assigned tasks for the shift." People also told us the registered manager was visible and actively involved in running the service. One person said, "The manager is around and chats [to me] once or twice a week." This was echoed by another person who told us, "I know the owner and manager very well; we see a lot of them."

Staff told us they felt the service had made significant improvements in recent months and this had helped reduce the level of staff turnover. One staff member said, "Things have really improved over the last six months. The atmosphere is so much better and we work much better as a team, which has made the people [who live here] happier, I think." Another staff member confirmed this and said, "I love working here, it feels so homely. The team is really good and everyone knows what they are doing." One person confirmed the benefits of consistent staff and told us, "We see more of the same faces now."

Staff meetings and management team meetings were held regularly. The meetings were used to seek feedback from staff and suggestions for improvement. Staff said the registered manager was "approachable", listened to them and valued their opinions. For example, a staff member described how they had suggested keeping daily records of care with each person's care plan rather than in a separate file. They said, "We now do this. Staff have got used to it and it is working better." The registered manager was a member of the national and local residential homes associations; they used these contacts, together with circulations from professional bodies, to help keep up to date with best practice guidance.

The providers had a clear set of values for the service. These were based on the ethos that staff should think the service is good enough for their own mother and should treat people as they would wish to be treated themselves. These values were communicated to staff during staff meetings and monitored by the registered manager while observing care being delivered. Most staff demonstrated a shared commitment to these values. Comments included: "I treat people how I would want to be treated"; and "I care for everyone

how I would want my own mother to be cared for; she would love it here".

We found the culture of the service was more open and transparent than at the previous inspection. The registered manager was working with a health and social care specialist from the Clinical Commissioning Group to develop and enhance the service. This had led to improvements to the environment of the home; to most staff's understanding of dementia care; and to the quality of care records. Staff relationships with community nurses had also improved. One of the community nurses told us, "At the moment, we do not have any concerns regarding Stonehaven." The registered manager notified CQC of all significant events and the previous CQC inspection rating was displayed prominently in the reception area. Relatives could visit at any time and said they were made welcome. There was a duty of candour policy in place; this required staff to be open with people and relatives when accidents occurred and the registered manager described how this had been followed where required.

Links with the community had been developed to the benefit of people. For example, members of a local charitable group visited three times a year to interact with people. Ministers from two local churches visited each month and some people were supported to attend services at one of the local churches. During the inspection, we heard a staff member ask a person, "Shall we go and look at the church, you like doing that?"

The registered manager operated a comprehensive quality assurance system which included a range of audits, including medicines, the environment and care plans. The medicines audit comprised daily, weekly and monthly checks and had been effective in ensuring medicines were managed safely. The audit of care plans confirmed that monthly and six monthly reviews of people's care had been completed. Where these identified changes that needed to be made, we saw they had been completed promptly; for example, a recent audit of one person's care plan identified that a 'night care plan' was missing and when we checked the care plan we found it had been completed. The infection control audit included inspections of three mattresses each month and this had helped ensure that people's mattresses were clean and hygienic.