Stronvar Rest Home Ltd

Stronvar Rest Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Stronvar Rest Home provides accommodation without nursing for up to 16 older people who may have dementia.

There were 15 people living in the service when we inspected on 24 May 2016. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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.

Procedures were in place which safeguarded people who used the service from the potential risk of abuse and staff understood the various types of abuse and knew who to report any concerns to.

There were sufficient numbers of trained staff to meet people's needs and recruitment processes checked the suitability of staff to work in the service.

There were appropriate arrangements in place to ensure people's medicines were obtained, administered and stored safely. However, guidance for staff on how and when to administer 'as and when required' medicines could contain more detail.

People were supported in accordance with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) however some staff had not had training and lacked awareness of what the Mental Capacity Act meant for people. The use of bed rails had not been recorded as being made in a person's best interests.

People's nutritional needs were met and people were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

People were treated with kindness by the staff by staff who knew them well and had good relationships with people who used the service.

People were provided with personalised care which was planned to meet their individual needs although more information was needed in care records about how people communicated and the support that they required at meal times.

People were encouraged and involved in making decisions about their care and were encouraged to pursue their interests and to maintain links within the community.

A complaints procedure was in place and people's comments, concerns and complaints were listened to and addressed in a timely manner.
There was an open and transparent culture in the service and staff understood their roles and responsibilities in providing good quality care to people who used the service.

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.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

There were enough skilled and competent care workers to meet people's needs.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were mostly trained and supported to meet people's individual needs. However, not all staff understood the Mental Capacity Act (MCA) 2005 or had up to date training in this area.

People's care records did not contain information about if they required any assistance with eating.

People were supported to maintain good health and had access to ongoing health care support.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy and dignity was promoted. Staff took account of people's individual needs and preferences.

The positive and friendly interactions of the staff promoted people's wellbeing.

People were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

People were supported to access the community on a regular basis.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well-led.

The manager was visible in the service and there was an open and transparent culture. Staff were encouraged and well supported by the manager and were clear on their roles and responsibilities.

Audits were completed to assess the quality of the service and these were used to drive improvement.

Stronvar Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 24 May 2016, was unannounced and undertaken by one inspector and an expert-by-experience who had experience of dementia care. 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 our inspection a Provider Information Return (PIR) was submitted by the registered manager. 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 looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with five people who used the service and one person's relative. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who may not be able to verbally share their views of the service with us. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to five people's care. We spoke with the registered manager and nine members of staff, including care, kitchen and domestic staff. We also received feedback from one health and social care professional and one relative.

We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service provided.

Good

Is the service safe?

Our findings

People told us that they were safe living in the service. One person said, "I am happy here and I feel safe." Another person said, "I am very safe, there is someone on at night patrolling." Three people told us about staff checking on them at night which made them feel safe.

Systems and policies were in place to reduce the risk of harm and potential abuse and staff had received training in safeguarding. They could tell us about their responsibilities to ensure that people were protected from abuse, knew how to recognise and report any suspicions of abuse and how they would report their concerns to the appropriate professionals. One professional told us, "I have never seen any malpractice or bad treatment and everyone seems happy. No concerns."

We found that there were some obstacles, such as a trailing telephone wire in a bedroom and a large picture leaning against a wall, which could cause a risk to people as they mobilised around the service. We spoke to the manager of the service about these risks and we saw that staff took prompt action to remove these risks immediately. There were excess pads being stored in some people's bedrooms. The manager explained that due to the building work being carried out at the service at the time of inspection, this had reduced the storage areas available. The manager assured us that this was not a risk to people and would be rectified as soon as the building work was completed.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised and these had been signed by staff to show that they had been read and understood. This included risks associated with mobilising, pressure ulcers, nutrition and falls. Where people were at risk of developing pressure ulcers, records showed that actions were taken to minimise the risks. For example, the use of pressure relieving equipment and regular repositioning. The records of one person who was at risk of developing pressure ulcers showed that regular checks were made on the mattress, equipment and hygiene to reduce these risks. We saw that where a person's needs changed, the risk was reviewed to ensure that people's needs were met appropriately. For example, where a person's mobility had changed, a hoist was put into place to ensure they were supported to mobilise safely.

We saw that the lift was not working on the day of our inspection as a new part was required. This was discussed with the manager who told us that people were using the stair lift while the lift was not working and how this was being managed safely. For example, people were only using the stair lift with a member of staff observing and there were instructions on the back of people's bedroom doors to reduce the risk to people while using the stair lift. Checks had been made on equipment to ensure that it was safe to use and fit for purpose. For example, walking frames had been checked to see if they required new ferrules. There was guidance available for staff on the action to take in an emergency. For example, if the lift stopped working or in the event of a fire. People had personal evacuation plans in place, fire drills had been held and fire instructions were given annually so that people knew what to do in the event of a fire. This showed us that people and the staff team were provided with the information required to keep people safe.

People generally told us that there were enough staff available to meet their needs. People told us that call

bells were answered promptly. One person said, "Staff come as quick as they can, you don't wait too long, depends if people need two of them [staff] but overall there is enough staff." Another person commented, "Someone always comes eventually but you don't normally wait long." and a relative said, "They are very quick to answer and help [relative]." However, one person told us, "They [staff] don't really have time to stand and talk, they have to go onto the next one when the button goes." The manager assessed the staffing levels based on people's needs. We saw that staff were attentive to people's needs and requests for assistance were responded to promptly. We saw that all necessary checks had been completed on newly recruited staff prior to them taking up employment to ensure their suitability for the role.

Suitable arrangements were in place for the management of medicines . People told us they received their medications when required. We saw that when staff provided people with their medicines this was done safely and respectfully. One person said, "They are always on time, it is not a problem." Another person said, "I do have a list of them [medicines] in my room and when I go out I take my tablets with me." We observed a member of staff administering a medicine and explaining to the person what they were taking and checking that they were happy to take it. Medicines were provided to people as required with food or at certain times.

Medicines, including controlled drugs, were stored safely for the protection of people who used the service. Records showed when medicines were received into the service and when they were disposed of. Staff recorded that people had taken their medicines on medicine administration records (MAR). Weekly audits on medicines and competency checks on staff were carried out. These measures helped to ensure any potential discrepancies were identified quickly and could be acted on. There were medicines policies and good practice guidelines in place for staff. For example, on how to administer medicines such as eye drops. There was a reporting form in place for any errors which included lessons to learn to prevent any re-occurrence. During the inspection, the stock count of one medicine was not correct. We saw that this was investigated immediately by the management, an explanation given for the discrepancy and action taken to prevent it happening again. There were some guidance in place for medicines that were prescribed to be administered as and when required (PRN). However these could be more detailed to include signs and symptoms that the person may display and precise reasons for administering that particular medicine.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that the staff had the skills to meet their needs. One person said, "Yes, they are trained." One person's relative told us, "Staff are so experienced they know when to call in health professionals and they [health professionals] recognise the staff's knowledge and experience and don't question that they have been called in."

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were regularly supervised and supported to improve their practice. This provided staff with the knowledge and skills to understand and meet the needs of the people living in the service. New staff completed the Care Certificate, an induction, and shadowed experienced members of staff before working on their own in the service. One staff member told us, "Only been here a few months and did a round with a senior. I have just done a Parkinson's course and manual handling and starting medication training." Another staff member told us and records showed that they had completed training on manual handling, dementia, food hygiene and first aid.

Staff were knowledgeable about their work role, people's individual needs and how they were met. Team meetings were held and staff had supervision and felt well supported by the management of the service. One staff member told us, "I can talk to any senior. You are allocated to a senior and any problems you can talk to them, the manager's door is always open and you can always talk to her. " A senior staff member told us, "We have supervisions, observation of practices, training and development. We try to encourage staff to get to senior level. We get them to act up when we have sickness and holidays." This showed us that the service actively supported the development and progression of its staff.

We observed staff assisting people to use mobility equipment. One professional told us, "Staff are using the correct equipment and following the plan which means that the person's wound is healing." This showed us that the moving and handling and pressure care training the staff had been provided with was effective.

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.

The manager understood when applications should be made and the requirements relating to MCA and DoLs and gave us examples of when relevant applications would be made under DoLS to the relevant

supervisory body, where people living in the service did not have capacity to make their own decisions. We saw that one person had bed rails in place which was not covered in the DoLS authorisation and the decision had not been recorded in the person's best interests. The manager agreed to discuss this with the person's power of attorney. However, another person's records who required the use of bed rails for their safety, did include information to show that the decision for these was made in their best interests. The manager told us the actions that they had taken to make sure that people's choices were listened to and respected. There were consent forms in place which were signed by people and we could see that people's capacity had been assessed. For example, when making everyday decisions.

We saw that staff sought people's consent and acted in accordance with their wishes before they provided any support, such as if they wanted to participate in activities, if they needed assistance with their meals and where they wanted to be in the service. Care records included that staff needed to be aware of capacity changing due to a change in people's health. For example, when a person was using oxygen.

Some staff had a good understanding of the MCA and consent and some staff lacked awareness. One staff member said, "I did a booklet on MCA. It's about the resident having a right to their own choice but they may not have the capacity to make a decision so we may need to make the decision in their best interests." Two staff members that we spoke to did not know what the MCA was and how it affected people's lives. Training records showed us that not all staff had received training in MCA and DoLs and the manager agreed that staff required additional training in this area. After the inspection, the manager told us that the training had been planned for staff to attend.

People were complimentary about the food and said that they had a choice of what to eat. One person said, "The food is perfectly acceptable and if you say you don't like either of the options for instance, I don't like salad, I have the meat in a sandwich." Another person commented, "I like the food, it is good basic food. The kitchen assistant asks me if I would like bacon and egg and I have that sometimes." One relative had made a compliment which said, "Always a good choice of food which is well presented." There was an availability of snacks and refreshments throughout the day. Some people did comment that it was a long time between the evening meal and breakfast time with one person telling us, "The evening meal is 4.30, it is a bit early but if you want something in the evening they do get it for you. The night shift will make you a jam or cheese sandwich if you want it, it is never a problem and you never go hungry."

At lunchtime we saw that all the meals were nicely presented and brought to the table with a metal lid over the top to keep the food hot. We heard staff offering assistance and gaining consent before helping people. For example, "Would you like me to chop this up for you?" and, "Would you like any apple sauce on that?" We saw that people's independence was promoted. For example, one person had a plate guard and was managing to eat their food independently. However, there was limited information in care records about the practical support people required to eat, for example if they required assistance or if they needed a plate guard. This was discussed with the manager who told us that they would add this information into the care records.

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Where issues had been identified, such as weight loss or difficulty swallowing, guidance and support had been sought from health care professionals, including dieticians and speech and language therapists. This information was reflected in care records and used to guide staff on meeting people's needs appropriately. The cook told us that meal options for people with diabetes were provided and said, "We have a diabetic choice on the menu. The custard is made for those with diabetes." We asked staff whether people had dementia friendly foods, For example, finger foods, and staff did not have knowledge of dementia friendly food and how this could be of benefit to a person living with dementia.

The manager told us that photographs of food were used to help people choose what they wanted to eat.

We saw that there were no names or pictures of anything personal to a person on their bedroom doors. There was no dementia signage in place which could make it easier for people to find the toilet or their bedrooms. This was discussed with the manager after the inspection who told us that the use of dementia signage had been discussed and the use of photographs of people on their bedroom doors was being considered to make it more personal.

People's health needs were met and where they required the support of healthcare professionals, this was provided. The manager told us that the service had a good relationship with the local GP surgery. One person commented, "Anytime you are worried they get the doctor in, the chiropodist comes and the nurse comes and does blood tests, optician comes. Every service there is, they come." Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. Where changes in people's wellbeing were identified, prompt action was taken to seek guidance and treatment from health professionals. The outcomes were clearly recorded and taken into account when planning people's care.

Good

Is the service caring?

Our findings

People told us that the staff were caring and treated them with respect. One person said, "Staff do a good job, they are kind and helpful." Another person told us, "They are very good, staff are lovely." One relative had complimented the staff by saying, "Staff are kind and efficient and very caring, and they all do a difficult job very well."

There was a calm and homely atmosphere throughout the service on the day of inspection. One person told us, "I cannot imagine being anywhere else better, it is not big and it is homely," and, "My visitors say that they have never seen an atmosphere like this one here." People were clean and dressed in appropriate, well laundered clothing. One staff member told us, "It is very good here; people are very well looked after." We saw that the staff treated people in a caring and respectful manner. People were clearly comfortable with the staff, they responded to staff interaction by smiling and chatting to them. We saw lots of laughter and staff having a joke with people.

There was no detail in people's care records about their preferred method of communication, level of understanding and the best way for staff to communicate with each individual such as getting down to that person's level or maintaining eye contact. This meant that staff may not know the best way to consistently communicate with a person. However, we did see that when communicating, staff positioned themselves to people's eye level which promoted effective communication. This was discussed with the manager who told us that they would add this information to the care records. We also observed through the day that staff were effectively communicating with people. For example, using a whiteboard to write down when a person had a medical appointment.

We saw the manager explain a letter to a person in a clear and respectful way regarding a recent hospital appointment so that the person understood what the letter said and what would be happening next. We saw that staff were promoting independence by encouraging people to walk themselves, read their delivered newspapers or use the telephone in their bedrooms.

We saw that there was a lack of private space that the staff team or visitors could use to discuss anything confidentially. The staff had used the dining area for their handover and one person had been asked to move into another room so that the handover could take place. This was discussed with the manager and they said they would give some thought as to how and where to hold private meetings so that these did not impact on people living at the service.

People told us that they felt staff listened to what they said. One person said that staff were always willing to stop and talk. Another person told us about spending time with their keyworker, "[Staff member] is friendly and I can speak to her, she is a good listener." One staff member said, "I often go and see [person] and see if there is anything to report. I add this to the care plan. It's nice and I get on well with them." We saw that staff listened to people about how they wanted to be supported, for example, if they needed assistance with their personal care needs and with cutting up their food.

We saw that staff respected people's privacy and dignity. For example, by asking people if they wanted to wear aprons during meals to prevent food spilling on their clothing. When asked about privacy and dignity, one person told us, "Yes I think it is respected." People told us and records showed that people's choice and independence was promoted and respected. One person said, "Yes I am listened to and I can make my own choices like when I get up and go to bed when I want." People had keys to their bedrooms and we saw that there were keys available for the patio doors for people who wished to go out into the enclosed courtyard or the garden.

There was a poster displayed giving people details of a local advocacy service that they could use if they required any additional support. These details were also provided to people in the service user guide.

Good

Is the service responsive?

Our findings

People told us that they received personalised care which was responsive to their needs. One person said, "They [staff] help me dress and change my clothes, they bring my meals to my room, my choice, I do go to the restaurant occasionally." Another person told us, "It is very good, more like an ordinary home and I get lots of freedom, you can get a cup of coffee when you want and I can go into the garden but someone has to come with me." One person's relative told us, "We are very happy, very content and we have peace of mind that [relative] is looked after. [Relative] comes out with us and they [staff] encourage it, it is not a problem even if we get [relative] back late."

Care records were person centred and reflected the care and support that each person required and preferred to meet their assessed needs. Where people had specific conditions, there was information in the care records about how these conditions affected the person's daily living. For example, how a person's condition could change daily and how they mobilised. We saw that care records were routinely updated when changes had occurred which meant that staff were provided with information about people's current needs and how these were met. The manager showed us the system that was used to update the records.

People's daily records contained information about what they had done during the day, what they had eaten, how their mood had been or if their condition had changed. Throughout the day staff communicated effectively with each other and used a communication book to reflect current issues as part of a formal handover to staff on the next shift. This made staff aware of any changes in people's needs on a daily basis.

Staff knew about people, their individual likes and dislikes and how these needs were met. For example, one person needed oxygen and enjoyed accessing the community but the oxygen canisters were too big to transport so the service arranged lightweight portable cylinders which allowed the person to continue to enjoy community activities. This showed that the service had responded to ensure that the person was supported to participate in the social activities they enjoyed.

People told us about how their needs were met. One person told us, "I have a paper every day and I like to read. I go out with my [relative] and had my nails done. I sit in the courtyard under an umbrella and they [staff] brought me a coffee." Another person said, "I go down to breakfast usually but one day I was watching the swimming on TV and they [staff] asked me if I wanted to eat in my room and then a tray arrived." This showed us that the staff team were flexible in ensuring that people's needs were met.

People's records included information about their interests and hobbies. People told us that they did many activities within the local community such as going to lunch clubs, going to a local church and having afternoon tea. The activities that people took part in were mostly individually chosen and community based rather than group activities. There was the opportunity for people to partake in music and movement twice a week, singing and arts and crafts. One person told us, "I read 90% of the time and occasionally I go out. Last Saturday eight of us went to the YMCA tea dance and staff used their own cars to get us there." Another person said, "I go to the British Legion twice a week and have a chat and a pint." On the day of the inspection, we saw people going out with family and to a lunch club. The manager told us about one person

who was becoming frustrated due to difficulties with their co-ordination and had been introduced to colouring to improve this. We saw that the person was enjoying colouring during our inspection and had finished many pictures which they showed us. We saw photographs of people making greeting cards, decorating cakes and of a dog visiting the service. One person told us, "We do crafts on Fridays and we have done cards, sticky work, iced cakes, scrabble and some of us have daily newspapers."

Staff were always present in the lounge ensuring people were supported when they needed assistance and we saw that they also made sure all people received some social interaction. No people were left for long periods of time without staff speaking with them.

People told us that they could have visitors when they wanted them. One person commented, "Visitors can come anytime. Last week a [person] was poorly and [person's] family stayed the whole time, it was not a problem." Another person told us, "I have lots of visitors." This meant that people were supported to maintain relationships with those who were important to them and to minimise isolation.

All of the people we spoke with told us that they knew who to speak with if they needed to make a complaint. We saw the complaints procedure was displayed in the service and was given to people in the service user guide. The service had not received any formal complaints but had dealt with informal complaints such as clothes going missing and had taken action to resolve this complaint to the person's satisfaction. We also saw compliments that the service had received which included, "Grateful thanks for the love and care of [person]," and, "Thank you for your kindness, you must take great pride in Stronvar."

People told us about residents and relatives meetings that had been held. Records seen confirmed this. One person said, "I have been to two residents meetings." Surveys had been sent out to residents and relatives requesting people's views on the service. The responses received were positive. One person also told us, "There is a suggestion box you can use." One relative said, "I filled in a form asking about housekeeping and staff and have been to a relatives meeting and my [relative] also went to one. The copies of the minutes are kept where the post is at reception." We saw that where suggestions had been made, plans had been made to improve this. For example, regarding areas of the service that required updating, and building work was in progress at the time of our inspection.

Good

Is the service well-led?

Our findings

People knew who the provider and the manager were and told us that they felt that the service was well-led. One person said, "The manager is strict and efficient. I always have my say but you cannot change the rules, the manager does listen to you." Another person told us, "Any problems I can just go to the manager." One staff member told us, "I really enjoy working here. If we have any problems, we can talk to the manager. The manager and the seniors are approachable. " Another staff member said, "It is lovely here, the size, the owners, management and it is very different working in a small family home, it is all about the resident's not vacant beds."

The Statement of Purpose for the service clearly explained the vision and values of the service and included how people's cultural needs would be met including the opportunity to attend communion every month. People told us that they had attended communion.

The manager was very visible in the service. The manager told us that because they were in the service, a minimum of five days a week and worked alongside the seniors as part of the shift, they spoke with staff and people regularly and so could monitor the service on an ongoing basis and make improvements as required. Staff spoke highly of the service and were proud of it and also spoke of how the manager was supportive and had an open door policy. The service had an outstanding employee programme, where it recognised staff that had gone the extra mile. This was voted for by people using the service, relatives and staff.

The service had a small staff team and any issues or concerns were discussed at the time and dealt with promptly. The staff were aware of incidents and action required through the management entries in the communication book. We saw a form that was available for staff to record anything that needed to be improved and included an opportunity for them to suggest possible solutions, which allowed the team to develop their skills in problem solving. There were policies and procedures in place to provide guidance to staff and these had been reviewed regularly and signed by the staff team. There was guidance displayed for staff in the office on new infection control guidelines and the manager had written in the communication book requesting that staff read the guidelines.

The manager had completed audits of the service to identify any concerns in practice. Audits and checks were made in areas such as medicines and falls and the manager had involved the falls prevention team as a result of analysing the falls records. This showed that the service took action to involve other agencies where required to improve outcomes for people.

People were kept up to date with what was happening in the service by a newsletter which covered upcoming events and updates from the service such the progress of the refurbishment programme. Relatives were complimentary about the service and told us they felt involved and supported. One relative said, "We don't have any problems, they keep us informed and during [relative] last weeks the support they gave us was tremendous."

There were plans in place to continually improve the environment; this included replacing the utility area.

The manager recognised the limitations of the environment due to it being an older building but they made sure that people were provided with a homely environment to live in.

Staff told us that they felt supported. One staff member said, "We have a good team and the manager is good and efficient." Staff understood their role and responsibilities in providing a good quality service to people. One staff member said about working in the service, "It is a really nice home, people are really helpful and I feel more than welcomed here. People offer to help you and it is a really nice supportive team." Staff had an awareness of the whistleblowing procedure and who to contact if they had any concerns.