

Stanwell Rest Home Limited

Stanwell Rest Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We carried out a focused inspection on the 14 December 2015 to check whether Stanwell Rest Home has taken action to meet the requirements of a warning notice we issued on 21 September 2015. This report only covers our findings in relation to these topics.

We undertook an unannounced comprehensive inspection at Stanwell Rest Home on 7 and 10 July 2015 at which breaches of regulations were found. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Stanwell Rest Home' on our website at www.cqc.org.uk.

Stanwell Rest Home is registered to provide accommodation for persons requiring nursing or personal care. Stanwell Rest Home is a residential care home for up to 38 older people. At the time of our inspection 30 people were living in the home some of whom had physical disabilities or were living with a diagnosis of dementia.

The home had a registered manager. 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.

Risks to people's health and wellbeing were assessed and mitigating action was taken to reduce the risk. The risks to people were managed safely and risk assessments updated to reflect people's current needs.

The home had introduced a series of audits and improved the way they monitored the quality and safety of the service. Quality systems were effective in driving improvements in the home and actions were followed up and acted upon. Meetings were held to discuss quality systems and to review progress and support staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

The service was well led.

The quality monitoring systems had been reassessed and changed in order to monitor and improve services.

Care plans and risk assessments were now being updated regularly.

Team meetings were held to monitor the quality process.

We could not improve the rating for this key question from 'Requires improvement' to 'Good' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires improvement



Stanwell 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. The inspection was carried out to check that improvements had been made to meet legal requirements, identified in a warning notice served after our comprehensive inspection on the 7 & 10 July 2015.

This inspection took place on 14 December 2015 and was unannounced. The inspection was carried out by one inspector.

We reviewed the previous inspection report and information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke to three people living at the home. We also spoke with the registered manager, two team coordinators and the provider's representative. We observed staff providing care and support to people in the lounges, looked at care plans and associated records for three people living in the home. We checked minutes of meetings, accidents and incidents records, quality assurance records and some of the provider's policies and procedures.

We inspected the service against one of the five questions we ask about services: Is the service well led? This is because the service was not meeting some legal requirements.

Is the service well-led?

Our findings

At a comprehensive inspection carried out on 7 & 10 July 2015, we found the service was not well-led. We served a warning notice on the provider as appropriate arrangements were not in place to ensure that effective systems and processes were in place. The provider was required to take appropriate action by 26 October 2015.

At our previous inspection we found that a recent audit of the environment did not identify that people could access hot water tanks, which placed people at risk of burns. At this inspection improvements had been made. All hot water tanks were fitted with locks, and maintenance audits were produced monthly to monitor the effectiveness of the locks fitted and access to potentially dangerous areas. At our last inspection the audit had not identified that a person's privacy was compromised by a frosted glass window in their room that could be seen through, with a similar situation in a communal toilet. At this inspection improvements had been made and the windows had been fitted with a covering that could not be seen through.

At our previous inspection we identified that the registered manager had failed to ensure that internal auditing systems were effective. We found that care plans were reviewed each month by senior staff, to check they were up to date and met people's individual needs. However, the reviews had not identified the risk assessments and associated records for a person who was at risk of choking as these were not updated to show staff the current concerns. At this inspection improvements had been made and we found monitoring systems were effective. Immediate action was taken after the inspection with the person involved to explain guidance and possible consequences of not following guidance. All care plans and risk assessments were reviewed and agreed with the person. Actions to minimise the risks were clearly detailed and advice was sought from the relevant health professionals. These records were now being audited monthly and any outstanding actions acted upon by the team co-ordinators and registered manager.

At our previous inspection we found that care plan reviews and internal auditing systems had not identified the lack of records for a person who had sustained a "bump to the head" or that a falls risk assessment had not been updated following a person falling resulting in a fracture. At this inspection improvements had been made and a new form

had been introduced to monitor accidents and incidents. This included details of the accident and any notable contributing factors, a body map to highlight any injuries and action taken. Staff then used a new form to record findings on a 30 minute observation chart to start with then on an hourly basis. This was then reviewed after twelve hours, then after 24 hours and finally after 48 hours. We saw records had been completed using this new form for someone who had fallen. This had been audited to check action had been taken and the person's falls risk assessment had been updated to reflect the recent fall. The registered manager had reviewed the accident records to establish possible contributing factors and took action by consulting with the person's GP.

The registered manager used a system of audits to monitor and assess the quality of the service provided, these included care plans. Care plan audits were thorough and carried out on a monthly basis. We saw for one person that a list of appointments and activities they had attended had been recorded and written up on the new audit form as well as any concerns about their daily living activities and their wellbeing. An action required from the audit was more information required on how they like to spend their day needed adding to the care plan. A staff member told us, "I looked at care plans for someone recently as part of my audit and noticed that more information was required in some areas, for example in people's past history." A staff member told us, "I like the new review system, and feel it is going to be very beneficial as it helps pull things together."

The registered manager told us, that they had made changes to the auditing process to include a more straightforward system of auditing and the teams have been split into three teams and included all the staff including the night staff, so we all get involved in improving the quality of our quality audit systems." A staff member said, "We now get allocated twelve hours a week for each team just to complete the reviews and update care plans." They also said, "I feel really positive about this, so much easier and achievable, with a check list to see what has been done and what needs to be done so much easier."

The registered manager held management meetings with the head of the three teams. Minutes of a meeting held in November 2015 showed results had been shared following a recent audit of bath and showers being offered to people living in the home and bed changes. The results showed that one team required improvements. This was discussed

Is the service well-led?

and plans put in place to support the team which included appointing a new team co-ordinator. At this meeting the new incident and accident reporting forms and procedures were discussed and following feedback the accident audit form had been amended to enable more information to be added. Staff stated 'this worked better.' The monthly care plan review forms were also discussed stating that the care plan audit will now consist of three parts, the monthly review of the care plan, monthly review of the daily diary

records and the monthly review of the risk assessments. Once completed these needed to be passed over to the registered manager they can complete their care plan audit.

The provider had appropriate policies in place for all aspects of the service which were reviewed yearly. Staff were aware of the policies and where to locate them.