Roseberry Care Centres GB Limited

Stephenson Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 29 June and 6 July 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Stephenson Court provides care and accommodation for up to 46 people with nursing or personal care needs. Some of the people who used the service had a dementia type illness. On the days of our inspection there were 40 people using the service.

At the time of our inspection visit the service did have a registered manager in place, however, that manager had left employment and had applied to CQC to de-register. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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. A new manager had been in post for several months. They had applied to CQC to become the registered manager and their application was being considered.

Stephenson Court was last inspected by CQC on 29 April 2016 and was rated Requires Improvement overall.

At the previous inspection it was identified that staff mandatory training was not up to date and the mealtime experience for people varied greatly depending on which dining room they were seated in. During this inspection we found staff were suitably trained and the training was up to date. We found mealtimes were a pleasant experience for all the people who used the service and staff attended to people's needs in a timely manner. This meant the provider had taken action to address the issues identified at the previous inspection.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

Some people who used the service, and family members, raised concerns regarding the number of staff leaving the home. However, observations carried out during the inspection and reviews of rotas found there were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following legal requirements in respect of Deprivation of Liberty Safeguards (DoLS).

Care records contained evidence of people being supported during visits to and from external health care specialists. People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs.

People who used the service and family members were complimentary about the standard of care at Stephenson Court. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care plans were in place that recorded people's wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people based on their likes and interests and to help meet their social needs. The service had good links with the local community.

People and family members were aware of how to make a complaint, however, they had no complaints to make about the service.

The provider had an effective quality assurance process in place. Staff said they felt supported by the manager and enjoyed working at Stephenson Court. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys. Family members told us the atmosphere was friendly and it was a nice place for their relatives to live.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

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

Is the service effective?

Good

The service was effective.

Staff were suitably trained, received regular supervisions and were appraised in their role.

People were supported by staff at mealtimes and their nutritional needs were being met.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a

polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

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

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

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

Staff told us they were happy and supported in their role.

The service had links with the community and other organisations.

Stephenson Court

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 29 June and 6 July 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and an expert by experience formed the inspection team. 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 we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

A Provider Information Return (PIR) was not requested from the provider for this inspection. A PIR 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.

During our inspection we spoke with 12 people who used the service, seven family members and two health and social care professionals. We also spoke with the manager, regional operations manager, two nurses, two care staff, one activities co-ordinator and one maintenance staff member.

We looked at the care records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We carried out observations of staff and their interactions with people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand

the experience of people who may not be able to talk with us.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at Stephenson Court. They told us, "I definitely feel safe", "Yes I feel safe here" and "I feel safe here, it's good at night when I see the night nurses coming around". One of the people we spoke with during the inspection told us their call bell was not working. We reported this to the manager who immediately informed the maintenance staff. The call bell was repaired the same day.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. Nursing and Midwifery Council (NMC) checks for nursing staff had been carried out and we saw all nurse registrations were up to date. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff, and on an ongoing basis as necessary.

We discussed staffing levels with people who used the service and family members. They told us, "The two night staff were like my best friends, they have left and now we have had agency staff every night for two weeks", "Staff are leaving, three left recently they are short staffed and have to do extra, it is becoming an issue" and "A few staff have left and I am less happy with the new staff as they don't know him as well." We discussed staffing with the registered manager and looked at staff rotas. The manager confirmed some staff had left recently but told us recruitment of new staff was ongoing and the plan was to "over recruit", so there were sufficient staff to cover absences. Three new care staff had been recruited and were due to start work at the home once all the appropriate vetting checks had been completed. Agency nursing staff were used at the home, however, care staff absences were covered by staff employed by the provider.

We observed staffing levels and responses to call bells during the two days we visited. The manager showed us copies of the audits they were carrying out on call bell response times and told us they were going to use the results of the audits to review staffing levels and working practices. Staff we spoke with told us they were "busy" and covered extra shifts but did not raise any concerns regarding staffing levels. Observations during the two days of our inspection visit were that call bells were answered promptly and there were sufficient numbers of staff on duty to look after people safely.

The home is a detached building set in its own grounds. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available, and a monthly infection control audit was carried out.

Accidents and incidents were appropriately recorded and analysed to identify any trends, and action had been taken as necessary. For example, action plans, observation records and risk assessments were in place for people who had experienced repeated falls.

Appropriate maintenance checks and equipment servicing had taken place. These included Portable Appliance Testing (PAT), hot water temperatures, window restrictors, lifting and hoisting equipment, gas and electrical installation. Risks to people's safety in the event of a fire had been identified and managed. For example, checks were carried out on the fire alarm and firefighting equipment, fire drills took place regularly, and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy, which defined what abuse is, the responsibilities of staff, and action to take following any incident or allegation of abuse. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The manager understood their responsibility with regard to safeguarding and staff received training in the protection of vulnerable adults.

We checked how medicines were managed in the home. Medicines were stored in a locked treatment room and the room temperature was monitored to ensure medicines were stored at safe levels. Controlled drugs were stored in a separate, secure cabinet inside the treatment room. Controlled drugs are medicines that are at risk of misuse.

We looked at medication administration records (MAR). A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Each person's individual record included a photograph of the person, details of the person's GP, past medical history, allergies and what assistance they required to take their medicines safely. Records we saw were accurate and up to date. This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Medication audits were carried out by the nursing staff and the manager carried out annual medication competency checks of staff who were trained to administer medicines.

People who used the service told us, "I have it [medicines] at the right time and right amount", "I am happy with my medication" and "They [staff] give me my medication, they do it well."

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People who used the service told us, "Definitely, they [staff] know what they are doing. They are very helpful and nice", "I think the staff are trained", "The staff are quite competent" and "At one point I was thinking of leaving, I decided to stay as I think staff and the home are improving."

At the previous inspection it was identified that staff mandatory training was not up to date. Mandatory training is training that the provider deems necessary to support people safely. At this inspection we found that mandatory training was up to date and any due refresher training was planned. Mandatory training at Stephenson Court included health and safety, moving and handling, safeguarding, nutrition, mental capacity, falls prevention, first aid, dementia care, and fire safety. The manager used a training matrix to identify when training was due and notified the staff concerned.

New staff completed an induction and all new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervisions included a discussion on specialist topics, for example, whistleblowing, safeguarding, dignity, personal care and confidentiality. The new manager had not carried out annual staff appraisals, however, we saw on the appraisal planner that all staff appraisals were planned to take place between July and November 2017.

People were supported with their dietary needs and menu preference assessments had been carried out for each person to identify any special dietary requirements, allergies, and likes and dislikes. People's specific dietary requirements were identified and managed. For example, one person had been referred to a speech and language therapist (SALT) due to difficulty swallowing and the guidance provided by this professional was included in the person's 'Mealtime management plan'. A malnutrition universal scoring tool (MUST) had been completed for the person and an appropriate risk assessment was in place. MUST is used to identify people at risk of malnutrition. Records we saw were regularly reviewed and up to date.

At the previous inspection it was identified that the mealtime experience for people varied greatly depending on which dining room they were seated in. During this inspection, we observed lunch in both dining rooms and found meals were provided in a timely manner and people were offered choices. The food served was consistent with the menu on the blackboard and appeared to be hot and appetising. The chef, activities co-ordinator and care staff were friendly and conversed with people. We observed a person stating they felt cold. The chef offered to close a window, which they then did. We observed the chef offering a person an alternative dessert of chocolate mousse or sponge. The chef told me the person liked to have different food. We observed two staff members interacting and assisting two people to eat and people were supported to eat in their own bedrooms if they preferred.

The manager had recently carried out a menu survey with people who used the service and their family members to identify people's preferences and what they would like to see on the menu. The results of the survey were provided to the home's chef, who had created a new four week menu. People who used the service told us, "The food is lovely and very tasty", "I have breakfast, lunch and tea. I have everything going, it is lovely" and "It is a lovely place, I get all my meals. I have what I like. When I was off colour they brought breakfast to my room."

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 had a good understanding of their legal responsibilities with regard to the MCA and DoLS, and staff had received training in the MCA. Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment where applicable.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms had been completed for some of the people who used the service. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service and family members had been involved in the decision making process.

People's communication care plans described people's communication ability and preferences, and what action was required from staff to assist the person to communicate. For example, one person had difficulty communicating so staff were to ensure the person's call bell was in reach at all times and to make sure their speech was clear and coherent when talking to the person.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including SALT, community nurses, occupational therapists and GPs.

Some of the people who used the service were living with dementia. We looked at the design of the home for people with dementia and saw dementia friendly signage on communal bathroom and toilet doors. People's bedroom doors were clearly signed and painted in different colours. Corridors were well lit, wide and clear of obstructions, which helped to aid people's orientation around the home. Although there weren't any objects on corridor walls for tactile stimulation, there were many photographs, paintings and movie posters decorating the walls. As there was not specific accommodation at the home for people with dementia, the manager told us they felt it was important to get the balance of the environment right between those people with residential care needs and those with dementia. This meant the service incorporated some environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the standard of care at Stephenson Court They told us, "Absolutely, they are caring", "I have had great comradery with the staff, one comes to see how I am", "I am very, very happy here, they are really good to me", "They make my family members feel welcome and offer them a drink when they visit" and "The staff are very caring and thoughtful." Family members told us, "The staff are nice, he is quite happy here" and "The staff chat and talk to her, they really care."

The care provided by a member of staff had been commended in a recent letter by family members of a person who used to live at the home. They said, "A very special thank you to [staff member]. [Staff member] made a promise to us that she would look after [name] like '[name] was her mum'. These special words were kept and it will always stay with us that she really was cared for as we wished."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. For example, staff called people by their name, and laughed and joked with them while they gave them a cup of tea or supported them to mobilise around the home.

People had been involved in making decisions about their care and care records reflected the outcomes of these conversations. For example, one person liked their bedroom door left open and their light switched off during the night. Another person liked to wear pyjama bottoms and a top in bed, and get up after 8am in the morning.

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records described how staff were to respect people's privacy and dignity. For example, "Privacy and dignity to be maintained at all times" and "Always respect [name]'s decisions." We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Absolutely [treated with dignity]", "They [staff] ask my consent. They say 'is it okay if we wash you?'", "I can have a bath or a shower, whatever I want. I had one recently, it was lovely", "I used to have a room upstairs. My relative asked if I could move downstairs and they did this. It is better down here" and "There are four male carers here. I don't mind having my shower with a male carer helping me. I know if I wanted a girl [female care staff) they would give me one." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to be independent and encouraged to care for themselves where possible. For example, one person who used the service had been supported over a period of time to visit a local pub. The person was now able to visit the pub independently without staff assistance.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and social occasions in people's bedrooms. People and their family members were

complimentary about the bedrooms. They told us, "I am quite pleased about my room" and "This is the biggest room. I have my own curtains and have brought quite a lot of my furniture."

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the manager who told us none of the people who were using the service at the time of our inspection had an independent advocate but information on local advocacy services was made available to people.

People's end of life care wishes were documented in their care records. These recorded whether the person had a DNACPR in place, who they wanted to be involved in their end of life care and what their plans were. Some staff had completed a course at a local funeral directors regarding end of life and the funeral profession. The manager told us feedback about the course had been very positive and was booking the rest of the staff on the course.

Good

Is the service responsive?

Our findings

People's needs were assessed before they started using the service and a '72 hour admission draft care plan' was put in place until a full care plan was written.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account.

Care plans were in place for people and included eating and drinking, continence, mobility, personal hygiene, emotional wellbeing, skin care and pressure relief, medicines, and communication. Records we saw were regularly reviewed and evaluated, and reflected people's needs. For example, one person was identified as being at high risk of falls. The person's care plan described the measures in place and the action staff were to take to reduce the risk of falls, and an appropriate risk assessment was in place.

People who were at risk of pressure damage had appropriate care plans and risk assessments in place. Charts recorded when positional changes had been carried out and Waterlow tools were completed and were up to date. Waterlow is a risk assessment tool used to calculate the risk of people developing pressure sores.

Staff completed daily records for people they supported. These included details of any visits by healthcare professionals, diet and nutrition, continence and sleep patterns.

We found the provider protected people from social isolation. The home employed two activities co-ordinators, who told us activities were arranged based on people's individual needs and wishes. They also told us if the person was unable or unwilling to attend group activities, the activities co-ordinators would go to the person's room and carry out one to one activities. The activities co-ordinators attended a local forum for activities co-ordinators in the area to discuss best practice and share ideas. The activities board advertised the activities that were taking place in the home. For example, exercise classes, bingo, arts and crafts, reminiscence sessions, music therapy, singing and a pony visit.

The provider's complaints procedure was on display on the home's notice board and provided information on who to contact if someone had a complaint and the contact details for other organisations such as the local government ombudsman and CQC. We looked at complaints records and saw there had been two complaints recorded in the previous six months. These included details of the complaint, the action taken to investigate and resolve the complaint, the outcome of the complaint, and copies of any correspondence. People who used the service and their family members told us they knew how to make a complaint and would be comfortable raising any concerns.

The service had received a number of recent compliments from visitors and family members. These included, "Thank you for the wonderful care you gave to [name]", "Thank you for the compassion you have shown [name] while he was in your care" and "Cannot thank you enough for making the last six months of my mam's life special." This showed the provider had an effective complaints and compliments procedure

in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit the service did have a registered manager in place, however, that manager had left employment and had applied to CQC to de-register. A registered manager is a person who has registered with CQC to manage the service. A new manager was in post and had applied to CQC to become the registered manager, and their application was being considered.

The manager told us of their plans for the home. These included turning the existing manager's office into a hairdressing and beauty salon, a lounge that wasn't used often was going to be turned into a garden room where they could "bring the outside in", and replacement furniture for communal areas had been ordered.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had a positive culture and there was a pleasant atmosphere in the home. People who used the service told us, "It is a lovely place to live, "It is pleasant here", "There is a good atmosphere, we have a good laugh" and "I like it here." Family members told us, "The atmosphere here is alright, everyone says hello" and "The staff are friendly and it is a nice place. I am here most days."

People who used the service and family members were complimentary about the management of the home. They told us, "It is well managed and the nurses are very good", "I think things are improving since the new manager arrived" and "It is better since the new manager came."

Staff were regularly consulted and kept up to date with information about the home and the provider. Staff and senior staff team meetings took place regularly. Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. They told us, "I do like it here. I've been here a long time" and "Very happy here. Yes, lots of support."

The service had good links with the local community. Several groups visited the home, including a local organisation for people with learning disabilities, brownies, schools and the local college. A local pub donated prizes for the home's raffle and beauty therapy students visited to carry out therapy sessions with people who used the service.

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

We saw records of the provider's monthly 'Home visit report'. These included a review of records and charts, discussions with people who used the service, visitors and staff, general observations of care and cleanliness in the home, and staffing levels. Any identified issues were recorded in an action plan. For example, the manager was to carry out a minimum of three call bell audits per week and we saw these were taking place.

The manager and senior staff carried out regular audits. These included infection control, medication, and

care plans. These audits were up to date. The manager conducted a daily walk around of the home to check on the environment, observe care being carried out, and observe mealtimes. The manager delegated the task to a senior member of staff when they were not at the home. The manager also conducted night time spot checks of the service.

Meetings took place every two months for people who used the service and their family members. The manager told us these had not been well attended in the past so had suggested having meetings in the evening if it was more convenient for family members to attend. The manager was waiting for feedback on this suggestion.

The provider produced a newsletter every two months that looked back at recent events and activities at the home, and details of upcoming activities and events.

We saw the results of a recent satisfaction survey sent to family members of people who used the service. The survey asked questions on the quality of personal care and support, catering and food, daily life and activities, management, and the environment. The manager told us the feedback was being analysed and the results were going to be displayed on the home's notice board.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.