Roseberry Care Centres GB Limited

Stephenson Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

Stephenson Court is large two storey residential care home situated in the centre of Forest Hall, North Tyneside. The service is able to provide accommodation, nursing care and support to 46 older people, most of whom have physical and/or mental health conditions, including people who live with a form of dementia. At the time of our inspection 32 people used the service, of which 23 people required nursing care.

This inspection took place on 27 and 29 April 2016 and was unannounced. We last inspected this service in April 2014, at which time we found them to be meeting all of the regulations that we inspected.

The manager of the service had been in post since January 2016 and had started the process to apply to become the 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.

There were policies and procedures in place to ensure the smooth running of the service. These included a safeguarding policy which staff told us they understood along with their responsibilities towards protecting people from harm or improper treatment.

People told us they felt safe living at Stephenson Court. Recording and management systems were in place to support the staff to provide the service. We found that staff were using the systems well which enabled them to provide safe, good quality care. Record keeping was found to be accurate and up to date amongst the records we reviewed.

Everyone we spoke with told us they had no major concerns about staffing levels, although people, relatives and staff all told us that high sickness absence levels amongst the staff occasionally impacted on care delivery.

Checks on the safety of the home were routinely carried out by maintenance staff and by external contractors where necessary. Personal emergency evacuation plans were in place.

Medicines were managed in line with safe working practices. We observed a nurse administer medicines during the inspection which was handled safely and hygienically. Medicine administration records were well maintained.

Accidents and incidents were recorded and monitored to identify trends. Staff used this information to update care records and record reduction and preventative measures in risk assessments. People were referred to external healthcare professionals as necessary.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act

2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. We found that the manager had a thorough understanding of the principles and had acted in accordance with the law.

Staff received an induction and were trained; formal staff supervisions and appraisals had taken place with the staff whose records we reviewed. Staff attendance at regular refresher training was poor but the manager had an action plan in place to address this. Staff told us they felt supported by the manager and senior staff.

People were supported by staff to maintain a well-balanced, healthy diet. Food looked appetising and nutritious. The staff approach to person-centred care at mealtimes was varied which meant some people did not have a positive experience during these times.

We observed staff respected people, and their privacy and dignity was maintained. Staff displayed caring and kind attitudes and treated people as individuals, however we found that a small group of staff did not display these behaviours during a lunchtime observation. We saw all other staff offered people choices and encouraged them to make decisions about daily life where appropriate.

People participated in a range of activities. The service was developing their activities programme to better suit the needs of the people who used the service. Staff supported people to maintain links by welcoming family, friends and visitors into the home.

Everyone we spoke with told us they knew how to complain and would do so if necessary. Complaints were recorded and investigated as necessary and the manager had shared complaints with external bodies as required. 'Residents/Relatives' meetings and quarterly surveys were used to gather feedback about the home and the service provided. Health and social care professionals and other visitors were also asked to give their opinions on the service.

The manager held records which showed the quality and safety of the service was monitored through audits and an internal inspection process.

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.

People told us they felt safe living at the home. Relatives confirmed this.

The manager and staff displayed a good understanding of safeguarding people from harm.

Recruitment of staff followed safe practices and the manager ensured there was enough staff employed to meet the needs of people who lived at the service.

The premises were safe and secure.

Medicines were managed well and people received theirs in an appropriate and timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training relevant to their role; however this had not been routinely updated. Staff were inducted, supervised and monitored and competency checks were carried out by senior staff.

People were supported to maintain a balanced diet and the food looked appetising and nutritious. However, the staff approach to person-centred care varied throughout the home.

People's consent was sought in relation to their care and treatment. Where people did not have the capacity to make their own decisions about their care, the staff had documented evidence of best interest decision making in line with the Mental Capacity Act 2005.

External healthcare professionals were involved to help meet people's general healthcare needs and this was documented in care records.

Is the service caring?

Good

The service was caring.

Staff displayed positive and caring attitudes and interacted well with people.

Staff were knowledgeable about people and their life histories.

Choice was offered around aspects of daily life such as food, drinks and activities. Staff involved people in making decisions about their care and support where appropriate.

Staff had an understanding of equality and diversity and treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and health and social care needs were assessed. Reviews were carried out monthly and documented.

Activities took place and the team were developing the programme to ensure there was something suitable for everyone to engage with.

There was a complaints procedure in place and people told us they knew how to complain if they needed to. The manager held a record of complaints which were investigated and dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was well-led.

The home had a welcoming atmosphere. Staff told us they felt supported by the manager.

We saw that people who used the service and their supporters were consulted via surveys and meetings to obtain feedback.

Audits were carried out to ensure all staff complied with their responsibilities and that people received appropriate care and attention.

The manager demonstrated good governance. Records were kept to monitor the quality and safety of the service.

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 27 and 29 April 2016 and was unannounced. The inspection team consisted of one inspector 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.

Prior to the inspection we reviewed all of the information we held about Stephenson Court including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their registration obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In addition, we contacted the local authority contract monitoring teams and safeguarding adult's teams, to obtain their feedback about the service. Healthwatch North Tyneside had recently completed their own report and shared this with the lead inspector. We also asked the provider to complete a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

During our inspection we spoke with 10 people who lived at Stephenson Court. We spoke with 12 members of staff including the manager, the deputy manager, nurses, care workers and domestic staff, who were all on duty during the inspection. We also spoke with seven relatives of people who used the service, who were visiting at the time. We spoke with an external healthcare professional who visited the home during our inspection. A provider representative attended part of the inspection and we were able to talk with them about leadership.

We spent time observing care delivery at various times throughout the day, including the lunchtime

experience in both dining rooms; and we observed people engaging with activities. We carried out some of our observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed four people's care records in depth. We reviewed other elements of people's care, including generic risk assessments and medicine administration records.

We looked at six staff files, including a mix of staff who carried out care and non-care related roles. Additionally, we examined a range of other management records related to the quality and safety of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Stephenson Court. We heard comments from people such as, "I feel very safe and secure, more so than when I was at home." A visiting professional told us, "The home seems very safe, to me." We observed people moved safely around the home and staff used appropriate moving and handling techniques when they assisted people. The atmosphere in the home was relaxed and friendly.

The staff we spoke with were able to tell us about the providers safeguarding procedures. Senior staff explained how they also followed the local authority's procedures for reporting safeguarding incidents to them. The management records showed that staff had a good understanding, and that action had been taken to safeguard people where appropriate. Details of investigations and outcomes were recorded and referrals to external bodies had been made as necessary.

Staff told us they were not afraid to speak up, if they thought something wasn't right, and said they felt supported by the manager and deputy manager who they would not hesitate to approach with any concerns about people's safety. A staff member said, "The new manager is very approachable and I have no worries going to her."

People's individual identified risks and care needs had been assessed and were recorded in each person's file. They documented risks which people faced; such as falls risks and pressure area damage. The files were up to date and contained a checklist for staff to ensure each risk assessment was reviewed regularly. This meant that changes in people's needs were captured quickly and staff used current information to care for people safely. Personal Emergency Evacuation Plans (PEEP's) were drafted and held centrally by the manager. A copy was also kept in each individuals care file. PEEP's are individual assessments of a person's ability to mobilise in the event of an emergency, such as a fire. Instructions are recorded for staff to ensure they know who would require assistance in such circumstances.

The premises were well maintained and cared for. The entrance hall was a pleasant and welcoming space with a seating area. There was no malodour present throughout the home. All communal areas were clean, comfortable and nicely decorated. We observed and spoke with domestic staff who were on duty during our inspection to understand their role within the service. There were maintenance staff in post and we reviewed their records which showed they had attended to minor repairs and safety checks around the home. We examined other records related to the safety of the premises. We found gas and fire safety checks to be up to date. Electrical repairs and tests were being carried out on the day of our inspection. All of these checks were carried out by external professional contractors where necessary.

A 'significant event reporting form' was used to record accidents and incidents which had occurred in the home involving people and staff. Details were recorded along with any investigations, actions taken and outcomes. We saw these were audited by the manager and used to track trends such as, nature of injury and age groups. This meant the service was able to put preventative measures in place to keep people safer in the future.

Staff recruitment was safe and robust. Staff files contained evidence of pre-employment vetting. Potential employees had completed an application form, been interviewed and had their identity verified. Two references were obtained and full enhanced checks from the Disclosure and Barring Service (DBS) were carried out. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed. The staff we spoke with confirmed these checks had been carried out. Files included records related to the management of sickness absences and any disciplinary action taken. This showed that the manager had ensured staff were suitable to work with vulnerable people and their performance was monitored.

We examined the duty roster and saw that planned staffing levels were appropriate. The manager used a 'resident dependency' tool to calculate how high people's needs were and how many staff were needed to care for them safely. Staff told us they were often deployed to help out in other areas of the home when their colleagues needed assistance. The people and staff we spoke with did not raise any major concerns with us about the numbers of care staff on duty, however comments were made about the service being short staffed due to high levels of unplanned sickness absence. One person said, "Sometimes I have to wait for the toilet. Staff go off sick you know, and there's just not enough of them." A member of staff told us, "Staff sickness is a problem here, and it gets everyone down. We can't give the time to the residents. But when we are fully staffed it is great working here." A relative told us, "I think that although the staff are very caring, there is often not enough of them." We spoke with the manager about this who told us she had been monitoring sickness absences closely and staff with continued absences had been investigated. We saw evidence of this with 'return to work' interviews and investigation notes held on staff files.

We observed staff responded to people quickly and they spent time chatting to people. One person told us, "Staff come quickly (when the bell is pressed)." The call bell sounded many times during the inspection and we observed staff attended to people in a timely manner.

Medicines were well managed and people received their prescribed medicines safely. We carried out an inspection of a treatment room and spent some time with a nurse on duty while they carried out a medicines round. The treatment room was well organised and medicines were stored appropriately and securely. There was a procedure in place to return unused medicines to the pharmacy and these were stored in large, labelled, sealed containers whilst they awaited collection. Surplus medicines and 'build-up' drinks were also stored in a locked cupboard. Medicines which required refrigeration were stored appropriately and staff carried out regular checks of the temperatures in the fridge and the treatment room. Medicines which were only taken when required, such as for pain relief were also managed well. People had individually labelled medicines which were recorded, counted and monitored to ensure safe administration. We carried out a random check of the controlled drugs. We found these were also safely and securely stored and monitored. Controlled drugs are those medicines which require tighter legal control measures under the Misuse of Drugs Act 1971. We saw that nurses who administered medicines had completed a safer handling of medicines course and had undertaken an advanced medicines course with a local pharmacist.

We observed a nurse administer medicines to two people. The nurse explained what they were doing and what the medicines were for. They approached the person sensitively and spoke calmly throughout the interaction. The nurse administered the medicines in a safe and hygienic manner. We heard the nurse say to one person, "I'll come back later with your 'ensure' (build-up drink) in case you end up having a meal while you are out with your family." This meant the person received person-centred care which suited their individual circumstances. We observed the nurse completed people's medicines administration record after the tasks were finished. This meant accurate records were made with regards to people who accepted or refused their medicines.

Requires Improvement

Is the service effective?

Our findings

The staff team consisted of long term employees as well as new recruits. The staff team had a mix of knowledge, skills and qualifications. In the past staff completed a standard induction process, whilst new staff now embarked on the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective, compassionate care. The deputy manager told us they were responsible for ensuring staff completed the Care Certificate. They also told us they carried out competency checks with new staff around the fundamental skills as well as routine competency checks on all staff.

Staff files showed that historic training had taken place. A staff member said, "We have regular training from various training agencies' and specialist training when it is required." However the management records which related to staff training showed that the service lacked compliance with regular refresher training. The manager was aware of this issue and told us that since she came into post she has made a conscious effort to ensure staff attended mandatory training sessions. She said, "We have had a poor response in the past for attendance, but we have new procedures in place to prevent this in the future." We saw notes in staff files that these new procedures had been discussed with staff. We also saw that training in topics such as, Health and Safety, Food and Nutrition and Fire Safety were planned to take place in May 2016.

Supervision and appraisals took place. Records in staff files showed that routine supervisions were held as well as supervision sessions which were carried out after misconduct had occurred. For example, following a minor error a staff member received four two-weekly supervision sessions. All of the staff files we examined contained recent supervision session notes which covered topics such as, understanding conduct in relation to smoking breaks, fire drills and sickness absence. We saw staff received a 6-monthly performance appraisal. A staff review which was carried out in February 2016 included the staff members review of themselves, areas of performance, follow up on previous actions, areas for development and an action plan. This showed that staff were supported to fulfil their role by the manager. Staff told us, "The manager is approachable and I see her every working day" and "The atmosphere among the staff is much better now because of the new manager."

Staff meetings were held regularly. Daily meetings took place between the heads of each department and a handover was given to the oncoming staff. This was to ensure information was communicated effectively and incidents or actions to be taken were not overlooked. Monthly meetings were held with the different staff teams. We reviewed the meeting minutes from the last three meetings between the nursing team, care team, catering team and domestic team. The agendas of each meeting were designed around the team's role within the home with items including safeguarding and health and safety being regularly discussed. Feedback had been given to all staff following a local authority inspection and reflective learning was shared from incidents and accidents which had occurred.

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 it is in their best interests to do so and when it is 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 provider was working within the principles of the MCA. Care records showed, and the manager confirmed that most people living in the home were subject to a DoLS. We reviewed the records regarding the applications to the local authority and outcomes of these decisions. The manager had also notified the Care Quality Commission of these applications and decisions. People who lack mental capacity may still have the ability to consent to some aspects of their care and treatment. People should be included in the best interest decision making process along with their supporters. We saw in care files that people were routinely involved in the decision making process as far as reasonably possible.

During the inspection we observed the staff over 'lunchtime'. There were two communal dining rooms and we observed the experience in both of them. Both dining areas were beautifully laid out with matching table cloths, folded napkins, cutlery and condiments. However, the mealtime experience for people varied greatly depending on which dining room they were seated in.

The upstairs dining room was small and people appeared to be squeezed in. We observed the staff gave out cups of tea. There was no other choice offered. We asked a member of staff about the drinks, she said, "That's all there is". There was only tea and 'build up' milkshake style drinks on the trolley. Staff wandered in and out of the dining room throughout but there was little interaction between staff and people. We observed some people sitting in awkward, uncomfortable-looking positions. One person was moved from the upstairs dining room to the downstairs dining room due to the lack of space and there was no interaction between staff and the person to explain this. While waiting for the food to arrive, two people had an altercation about a teacup. There were raised voices and the cup was banged on the table several times. No member of staff was present and they were unaware this had taken place. One person, who had been coughing throughout, refused their food, stating they had a headache. The food was removed and a milkshake was placed in front of them which they did not drink. One resident who was in a very large chair, placed at the side of a table, had a tray on their knee with a meal on it. They sat throughout the meal with a fork in one hand and a cup in the other; they could only get a very small amount of food onto the fork and was clearly having difficulty getting the food to their mouth. They were not offered any assistance from the staff during this time which meant that all everybody's dietary needs were being met.

The downstairs dining room was observed to be a completely different experience. During the 45 minute observation, we saw lots of positive interactions between staff and people and staff were extremely courteous. We heard comments such as, "Hello sir, can I just put this apron on to protect your clothes" and "Hello (person's name), are you okay? I will serve you your dinner – is that okay?" The staff were attentive to everyone in the room and coped well with some behaviours which challenged them. The mood in the room was quite neural although one person sang along with the background music throughout their lunch. Staff offered choices of drinks, meals and portion sizes. The meals smelled lovely and looked very appetising. We heard comments such as, "(Person's name) just wants mash, gravy and a little bit of veg" and "Do you want to try another pudding or are you full". We observed the nurse in charge talking discreetly to care staff about people who were refusing their meal. The nurse directed care staff with strategies for encouraging people to eat something.

We discussed our observations of lunchtime with the manager, deputy manager and provider representative. We had already noted that the lack of a person-centred approach at mealtimes had been identified in the recent local authority inspection and that the manager had fed this back to the staff teams

during a meeting. Although the upstairs experience was still negative, we saw the staff downstairs provided an exceptional person-centred approach. The manager told us that there were plans in place to address the shortage of space upstairs. The manager also told us she would address the attitude of the staff with the individuals involved.

People and relatives told us they enjoyed the food served at the home. One person said, "The food is always nice here". A relative told us "We were able to eat meals with our relative, which was lovely." The kitchen staff were aware of people who required soft diets, people who had allergies and people who were diabetic. The information was updated as needs changed on a board located within the kitchen. New daily menu boards were in place in the dining areas and a four-week menu plan was also on the wall. There was a lot of flexibility and people chose in advance what they would like to eat. If people changed their mind this was not a problem for the staff. The kitchen staff told us that a variety of 'summer' meals had been introduced and the 'winter' meals were gradually being taken off the menu. They also told us about one person who was 'gluten-free' and they had their own ingredients labelled in the kitchen storage areas. Some relatives had brought in various food items such as home-made jam and they were also labelled and stored appropriately.

The people we spoke with and their relatives told us that there was good access to external healthcare professionals in order to meet general healthcare needs. A relative stated, "They [staff] let us know if a GP is needed." Another said, "They [staff] are very good at getting professional help and involving the family." A person told us, "I know that if I need professional input, I will get it." The records we reviewed showed that people had seen their GP, a dentist or a chiropodist if they needed to. We also saw people had been visited at the home by an optician. Details about these visits and any instructions for care staff to follow were documented in the person's care records.

We saw that bedrooms doors were painted with contrasting colours from floors and walls. This showed that the home was designed around some best practice guidance regarding caring for people living with dementia. The home had a garden area which was accessible to everyone. We were also shown a designated indoor 'smoking room' for people who wished to smoke. This was clearly signed and had protocols for use and risk assessments in place to ensure people remained safe.

Good

Is the service caring?

Our findings

Apart from the observation over lunchtime, we saw staff approached people with a positive and caring attitude. The home had a happy and homely atmosphere. We saw staff carry out their roles with compassion and kindness. One person told us, "Everyone is kind; they'll [staff] do anything for you." Another said, "The staff will always go the extra mile for you."

The staff we spoke with knew people well and were able to tell us about individual people's care needs and their life histories, although the care records did not contain sufficient information about the past life history of each person. A relative told us, "Staff fit in with my mother's way." One person told us, "I like being here, staff are very kind, I can choose what I want to do. I am happy with how they wash and dress me." We saw people had personalised their own room with furniture, photos and ornaments. The home had a resident cat that people took pleasure from petting. Nobody had their own pet, although this could be allowed subject to the manager's discretion.

We asked a staff member to tell us about the care required by a particular person. They were very clear, correct and thorough in their description. They added, "I always treat people with dignity and respect because it is the right thing to do. It makes people feel comfortable and happy." All the staff we spoke with displayed respect for people and demonstrated how they maintained privacy and dignity. One person said, "The staff definitely do treat us with dignity and respect. They keep me covered when doing my personal care." A relative said, "Staff are very respectful, exceptionally so. Which is nice."

Staff records showed staff were trained in equality and diversity. We observed staff treat people as individuals and saw people's preferences, different needs and circumstances had been taken into account. For example, religious and cultural preference were considered and the service welcomed religious groups in to the home. Staff told us they sometimes supported people to attend their own church.

We observed staff upheld and maintained confidentiality. Records about people and staff were kept locked away and confidential information was protected. On several occasions, we saw staff talking discreetly with people about their needs. A relative told us, "They respected my mother's right to confidentially when she did not want us to know something. This is good."

Regular 'Residents and Relatives' meetings took place. A relative told us, "They always keep the family involved." We reviewed the minutes of the last four meetings. We saw on average four or five people attended these meetings. Discussions were had about improvements within the service and people were asked for their opinion on developing a monthly newsletter to keep people informed. The care records we reviewed demonstrated that people had been involved as much as possible in the development of a plan about their care and support.

There was information and explanations on display around the home about aspects of the service. In the main entrance there were posters on display with photographs of named staff who were 'champions' in topics such as safeguarding, infection control and dementia. Photographs of the staff on duty were also on

display. People were given a 'service users guide' upon admission and these contained a wealth of information about the service; what to expect, what is on offer and the local amenities available.

We asked the staff whether any person using the service currently used advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. We were told that the service could access an advocate from a variety of providers if people needed this support, however, most people had family who acted on their behalf informally. Some people had legal arrangements' in place with relatives acting as a lasting power of attorney for finances and health matters and this was evidenced in their care records.

We observed people, with the ability, moved freely and independently around the home. They could access communal rooms and activities as they wished. Staff provided only necessary assistance and promoted people to be as independent as possible with tasks such as personal care, eating and activities.

At the time of the inspection, there was nobody receiving end of life care and treatment. We saw the service has considered people's end of life wishes and where people had shared these wishes, these were documented in care records. We saw appropriate documentation regarding emergency healthcare and resuscitation had been completed by some people. A number of staff had been trained in palliative (end of life) care. We saw on display a 'thank you' card which read, "A special thank you to the staff who supported my mother and ourselves during the last phase of her life."

Good

Is the service responsive?

Our findings

The four care records we examined in detail were thorough and informative. Two of these files were in the process of being changed to an improved order. Each person had been given a named nurse or keyworker. These people had the responsibility to ensure the records were reviewed and kept up to date. The records contained information taken at pre-admission in order for the service and external health and social care professionals to determine that Stephenson Court was a suitable place to meet the person's needs. The records we reviewed contained assessments of all aspects of people's care and support needs such as mobility, medicines and meals. Care plans had been drafted to support the staff to care for people appropriately. We saw specific care plans and risk assessments relevant to people's needs such as memory, falls, continence and pressure area damage.

Progress documentation, daily notes and observation charts were in place to record information about weight, food and fluid intake and body mapping. We reviewed these documents and cross checked them against the daily information noted by care staff. We found these were completed adequately. Some of the care records showed people were checked on every hour by the staff. Observations were recorded in relation to general well-being, pressure areas and the safety of equipment being used. Supplementary information was kept about people's general health and social care needs and shared documentation from partnering organisations such as the NHS was used by the service to support their own paperwork.

Records were person centred and contained specific information relevant to each person. For example, one person had an Alzheimer's Society leaflet called, 'This is me' completed. Another held a 'Forget Me Not' booklet which was entitled, "A little information about you and what is important will make your stay more comfortable and less stressful". People and/or their relatives had been involved in completing these. The service also used these documents to share important information with other professionals in the event of an emergency admission to hospital in order to ensure effective communication took place.

We noted that the majority of care files lacked comprehensive life history information such as, information about people's previous occupation, interests, hobbies and memorable events. We fed this back to the manager who assured us this was in the process of being updated. We saw that the manager had asked relatives at a recent meeting about assisting with life history information regarding their family member.

The four records we examined had been reviewed recently. There was a review document in place and a meeting had occurred between the person, their relative, a nurse and a social worker. Each party had made comments which were recorded. The document was signed as correct by the relative.

After a general engagement event in September 2015, an independent observer provided Healthwatch with a report which stated, "We noted that Stephenson Court was considerably poorer than other homes in providing activities suitable for people living with dementia." There was an activities programme in place and the service had recently employed a second activities coordinator. Both were in the process of working on a new and improved programme to offer people more meaningful activities. On the day of our inspection, the activities included a reminiscing session and a quiz. The hairdresser had also made a weekly

visit. We saw people in 'the salon' enjoyed the quality time and being pampered. The service encouraged people to take holidays and supported people to arrange these. For example, the service offered the opportunity for people to 'exchange' with a person in another of the provider's care homes from around the country.

The people we spoke with told us they were given choices in all aspects of their daily life. One person told us, "I am always asked when I would like to get up or go to bed." During the inspection we heard staff offering choices to people and encouraging them with small decisions. Care records showed that people had been given a choice on the gender of their preferred care workers.

The service has a complaints policy in place. We saw this had been shared with people in the 'service user guide' and was also on display on notice boards. One person we spoke with told us, "I did get a service user guide, but didn't read it. If I complained to the manager I would expect feedback. If I wasn't happy I would go to head office." Everyone we spoke with knew how to complain. A relative said, "I would speak to the nurse in charge or go to the manager, if I was not satisfied with the result I would go to head office." Another added, "The manager asks questions, checks everything is ok. She does listen and makes changes." A visiting professional told us, "You can go to the manager and she will act on any concerns."

We reviewed management information with regards to concerns and complaints. There were four complaints logged on the complaints register in recent months and some low level concerns regarding missing laundry, trousers being shrunk in the wash and a light not being switched on at night. We saw all of these had an action and outcome recorded. Complainants had been acknowledged, complaints were investigated and an outcome was recorded. We saw that reflective practice had taken place and learning had been shared with the staff during team meetings. There were some complaints still under investigation which the manager was dealing with in conjunction with external bodies.

Requires Improvement

Is the service well-led?

Our findings

The staff we spoke with told us they were happy at work and felt supported by the manager, deputy manager and nurses. One member of staff stated, "The new manager runs a tight ship and it's better for it."

Everyone we spoke with told us the manager was approachable and they had no hesitation to speak with her. One person said, "I feel I have a positive relationship with the manager and staff." Relatives said they were confident to approach the staff with any issue or problem they may have. One relative told us, "The manager is very approachable and listens and acts on any concerns we may have." We observed the manager and staff talked with people and relatives during the inspection, and displayed an open and transparent culture. The manager promoted an 'open door' policy and encouraged people and relatives to speak with her. We saw she ran a 'late night surgery' for relatives who visited out of normal working hours.

The manager had been in post for several months and had started the process to become the registered manager of the service. Once accepted, this means she will accept legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider is legally required to have a registered manager in post at this service. The manager had past experience of managing a similar type of service.

Prior to our inspection we checked whether statutory notifications were being submitted and we found that they were. The manager had sent several notifications to us about applications for DoLS and notifications of deaths or other incidents which had occurred at the home.

The manager maintained records about all aspects of the management of the service. These were inspected and found to be up to date and informative. We found general premises risk assessments and safety checks were up to date. Where major repairs were identified repair work was subsequently carried out by external contractors.

Guidance and information for people who lived at the home and for new people who may choose to move in was made available in a variety of formats. Including for example, a 'Service User Guide' and the provider's 'Statement of Purpose". We reviewed these publications which were on display during the inspection and found they contained a wealth of information about what people should expect from the service. This meant people and their relatives could make an informed choice regarding there care and accommodation needs.

A member of staff told us, "We have regular meetings to keep us updated." Another member of staff said, "I have input into the relatives meetings". Other members of the staff team told us about various input they'd had in aspects of the service such as activities and menu planning. The manager told us that the people who used the service had also been involved in the running of the home. Where people had shown an interest, they had been included in decisions about recruitment, fundraising and decoration. This demonstrated that the manager valued the views of others and involved them to ensure everyone was included and felt their opinions mattered.

The manager issued quality monitoring surveys to people who used the service and their supporters. The surveys were issued quarterly and there was evidence, that where feedback had been given, action was taken to address this wherever possible. We reviewed surveys from the first quarter of this year; January to March. This included two 'family opinion surveys' which were both positive and a 'professional's opinion survey' which was also positive. A staff survey had recently been issued and 14 members of staff had responded. These results were still being compiled. A recent survey was undertaken by the catering staff and 17 people who used the service had responded to the survey about meals. This had enabled the catering team to improve their service and offer meals which better suited people's preferences and tastes.

Internal audits were routinely carried out on care records, catering and medicine management for example. A recent catering audit had been conducted and the provider had given the home an excellent score of 98% with an action of replacing the seal on the refrigerator. During a recent medicine audit a score of 92% had been achieved. Actions from this included staff ensuring two signatures were always obtained and improvements were required when counting up medicine stocks. Areas for development of the service were also identified through audits. For example, the service was pursuing a review of the provider's policy with regard to homely medicines. Homely medicines are non-prescription drugs used to treat short term ailments such as headaches and constipation. Trends were analysed by the manager with regards to accidents and incidents in order to reduce or prevent further occurrences. This all demonstrated good governance and that the quality and safety of the service was monitored.

The manager was attempting to build community links which would benefit people who lived at the home. People engaged in the community and other activities locally. People from the provider's sister home across the road visited to join in with some activities. The service also welcomed visitors into the home to engage with people who could not go out. For example, entertainers, school children and religious groups. The manager and the activities coordinators hoped to involve more relatives in the publication of their monthly magazine.