The Hospital of God at Greatham

Stichell House

Inspection report

The Hospital of God at Greatham
Greatham
Hartlepool
Cleveland
TS25 2HS

Tel: 01429872083
Website: www.hospitalofgod.org.uk

Date of inspection visit:
14 July 2016

Date of publication:
30 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 July 2016 and was unannounced. We last inspected Stichell House on 20 August 2014 and found it was meeting all legal requirements we inspected against.

Stichell House is a care home without nursing and can accommodate up to 35 people. All bedrooms are single and have ensuite toilet and wash basin facilities. Accommodation is provided over three floors, all of which have tea bar facilities. There is a communal dining area and lounge facilities as well as attractive, landscaped grounds. Stichell House is situated on the edge of Greatham, a quiet residential village, in the Hospital of God estate.

At the time of the inspection there were 34 people using the service and one person was due to move in.

A registered manager was registered with the Care Quality Commission at the time of the inspection.

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.

Care plans did not always contain detailed information about how staff should provide support with mobility and continence care, for example how to support people with the use of specialist mobility equipment.

Audits were completed but the care plan audits were not always effective in identifying the concerns we noted in relation to the lack of detail in care plans. When this was raised with the registered manager they immediately started work on a new audit tool which focused on the quality and content of care records.

Audits completed by the care service manager and proprietors were detailed and involved speaking with people, relatives and staff for feedback on the service provided. Actions were recorded and the registered manager was able to respond to the actions with either an explanation or confirmation that tasks would be completed.

There was a culture of openness and transparency within the service. A visiting healthcare professional said, "The home is open and transparent and the manager is receptive to comments / recommendations."

Staff said they felt well supported and they received the training they needed to enable them to meet people's needs. One person said, "I'm really lucky to be here, excellent staff I can't praise them enough."

People and their relatives told us they felt safe living at Stichell House. Risks were assessed and there were control measures in place to support staff to manage risks appropriately. Medicines were stored,

administered and recorded in a safe way.

People told us there were enough staff to meet their needs and they did not have to wait for staff to respond if they needed any support. We observed staff spent time with people, and treated them with dignity, respect, compassion and care.

Staff understood the principles of safeguarding and mental capacity. People were actively encouraged to be involved in decision making about their care, and aspects of the home environment. Residents' meetings showed people had been consulted about recent refurbishments and use of rooms.

The activities co-ordinator was active in people's lives and spoke with people about their interests and hobbies, so activities could be meaningful for people. People were very complimentary about the activities and the efforts the activities co-ordinator went to with fundraising. One person said, "Special praise for the activity lady she keeps your mind going."

Meals were freshly prepared and people had a choice, but if they did not like what was on the menu an alternative was offered to them. Specialist equipment was available to support people to maintain their independence during meal times.

Access to healthcare professionals was supported and a GP clinic was held at the home every fortnight. This enabled people to see a GP regularly but also gave staff the opportunity to ask questions and seek guidance and recommendations if needed.

People and their relatives knew how to complain but said they had no reason to do so. Where complaints had been received they were investigated, recorded and action taken. There were many compliments recorded such as, 'excellent care provided – I only have praise for the work done, we are fortunate to have such a caring high quality facility.'

You can see what action we told the provider to take at the back of the full version of the report.

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 and their relatives told us they felt safe living at Stichell House.

There were enough staff to meet people's needs and people told us they didn't have to wait for support.

Medicines were managed safely.

Risk assessments were in place.

Is the service effective?

Good

The service was effective.

Staff had attended training which meant they could meet people's needs.

A plan was in place to ensure people received appropriate support, supervision and appraisal.

Mental capacity was understood by staff and where appropriate authorised Deprivation of Liberty Safeguards were evident.

People were supported to access healthcare and a GP clinic was held at Stichell House once a fortnight.

Is the service caring?

Good

The service was caring.

Staff knew people, and their relatives well and treated them with kindness, compassion, dignity and respect.

People were involved in decision making and had been consulted on refurbishments to the home.

The Gold Standard Framework for end of life care had been achieved.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans varied in quality and some lacked detailed information about how to provide the support people needed.

The dedicated activities co-ordinator was passionate about their role and worked with people to identify activities that would suit people. They were also a keen fundraiser which people appreciated.

People told us they knew how to complain but had no reason to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were in place but had not always identified that care plans lacked detail and were not complete. Other audits were effective in driving improvement.

The culture of the service was open and transparent.

Staff and visiting professionals said the registered manager was supportive, and their communication was effective and responsive. One visiting professional said, "It's one of the best homes."

Stichell House

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 14 July 2016 and was unannounced. This meant the provider did not know we would be visiting.

The inspection team was made up of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team, the safeguarding adults' team and healthcare professionals.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with nine people living at the service and three relatives. We also spoke with the registered manager, a duty manager, the activities co-ordinator, two care staff and a visiting healthcare professional.

We reviewed three people's care records and five staff files including recruitment, supervision and training information. We reviewed three people's medicine records, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. 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 could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe living at Stichell House. One person we spoke with said, "I feel safe, it's the best move I have made." Another person said, "Really safe. They watch and keep me safe." A relative told us, "I know [family member] is safe then I can sleep at night." Another relative said, "[Family member] is so safe, the girls talk to everyone, they know everyone. [Family member] rings the bell and they are there straight away. I go home and know [family member] is being looked after, there's nothing bad about the place."

A healthcare professional told us, "Yes, it's safe; they are very organised, caring when dealing with people, polite and considerate. The person is put first." Another professional said, "[Registered manager] takes the matter (safeguarding) seriously and is proactive in their approach."

One staff member said, "I've done safeguarding training. It's about meds errors, or abuse or bruising or skin breakdown. I would report anything to the seniors and document it." Staff had access to safeguarding guidance and where safeguarding concerns had occurred they were investigated and appropriate action taken. The Care Services Manager is a member of the local executive group for safeguarding.

Where risks had been identified risk assessments were in place. These covered areas such as continence, skin integrity, mobility and moving and handling. Risk assessments identified the hazards, who would be affected and what measures were in place to control the risks. All risk assessments were signed by an assessor and approved by their line manager. Reviews had been completed on a monthly basis however they did not record whether control measures should remain the same or if an update was required.

Risks in relation to the premises and health and safety were also assessed and managed. Checks were in place to ensure the safety and security of the home. All records were completed and up to date. This included regular assessments for fire alarms, fire equipment, electrical safety, electrical appliances, water temperatures and gas safety.

The provider had suitable plans to keep people safe in an emergency. Each person had a personal emergency evacuation plan (PEEP) which detailed the action to be taken in the event of an emergency. PEEPS were held in people's individual care records, in their rooms and in a central log accessible to staff and the fire service. Fire drills were conducted regularly for both day and night ensuring all staff had been involved. A duty manager told us, "[Maintenance man] will do the test without telling staff to see how staff react." One staff member said, "If the alarm goes off we meet at the fire point and wait for the fire marshal to direct us." Another said, "Make sure the residents are safe if you're with someone, go to the call point for instruction, phone 999, and evacuate. There are evacuation plans on the bedroom doors if you need them."

A new business continuity plan was in place to ensure people would continue to receive care following an emergency such as the loss of power. The plan detailed the actions for staff to take.

Accidents and incidents were recorded in a timely manner with a description of the accident and clear actions taken. Monthly analysis was completed to determine any trends for further investigation. The

information was reported to the Health and Safety Management group meeting where a report was produced outlining lessons learnt. The report is presented by the Director to the board of trustees to ensure governance of health and safety matters.

People and relatives told us there was enough staff to meet people's needs. One person said, "Enough staff to help us all." Another person said, "If I need them I know they are there." A relative said, "There is always someone about." One relative said, "There's generally enough staff, you might wait a few minutes but they do respond."

We observed a staff presence throughout the home and staff were quick to respond to people's requests. Staff engaged with people as they went about their duties in a friendly and affectionate manner.

We asked staff members if there were enough staff on duty. One staff member said, "Yes, there's enough, people don't wait, unless there's an emergency situation then there might be a bit of a delay." Another said, "There is. If someone phones in sick and we need to cover we have bank staff who know the residents."

A healthcare professional said, "Yes, there's enough staff, you need to wait sometimes but I've never felt they were understaffed, there's always someone around."

Recruitment files held an application form, interview record, two completed reference checks, one of which was from the previous employer and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. We noted two DBS checks did not confirm that checks of the adults' barred list had been conducted. This is a requirement for those working with vulnerable adults. We discussed this with the registered manager who advised they would ensure a new DBS check was requested. Confirmation that new DBS checks requesting a check of the adult's barred list had been requested was received.

We looked at how people's medicines were administered. One person said, "They keep me right with my tablets." Another person said, "I get my tablets, morning, dinner, tea and night time, whatever tablets you require they have them for you. Creams are held in the washroom. They are always locked away, always safe." Staff had attended relevant medicines training and their competency was checked on an annual basis. A duty manager said, "An external assessor did our training and observed competency for eye drops, and administration. [Manager] also does annual competency."

We saw people were spoken to in a respectful and supportive manner when their medicines were being administered. The duty manager explained they had the person's medicines and what they were for whilst ensuring the person had a drink available. Where people had 'as and when required' medicines prescribed for pain relief people were discreetly asked whether they were in any pain before any medicines were administered. The duty manager also checked the person's medicine administration record (MAR) to see what time the person had had any earlier medicines to ensure the appropriate time had lapsed between administrations. Medicine administration records were completed accurately. Topical medicine administration records were kept in people's rooms so care staff could record the application of prescribed creams.

Care plans, risk assessments and medicine profiles were in place as were protocols for the administration of 'as and when required' medicines.

Good

Is the service effective?

Our findings

We looked at the support and supervision staff received. The registered manager said the policy was for staff to have four meetings a year which includes an annual appraisal. We viewed a supervision matrix which detailed all the staff and the name of their supervisor. There were some gaps where staff had not yet attended two meetings this year. We noted the majority of staff had attended an annual appraisal.

The registered manager said, "We have got some gaps but the duty managers all know the requirements and who they are supervising. I'm raising gaps in their supervisions and there is a plan in place to make sure people receive the appropriate supervisions this year." The registered manager explained that there were gaps due to the recent restructure and there having been a period of time when there was no deputy in post and the restructure had not been completed. During this period of time the registered manager said, "There was a more informal structure so staff still had support but the matrix doesn't necessarily reflect this."

Staff told us they felt well supported and could go to the registered manager, duty managers or care services manager at any time they needed to. One staff member said, "We have supervision every six weeks or so, they are supportive, we can raise things." We asked if they had an annual appraisal. They said, "Yes we do." Another said, "Yes, we have supervision and appraisal, it's a safe space to talk in private, nothing is shared unless there's a concern then it goes to the manager."

A detailed training matrix was in place which showed that all care staff and domestic staff had attended training in moving and handling, dementia care, food hygiene, health and safety, safeguarding, mental capacity and DoLS (Deprivation of Liberty Safeguards). Some staff had also attended training in equality and diversity, depression and end of life care. The induction process for new staff was linked to the Care Certificate. The Care Certificate is an identified set of standard skills, knowledge and behaviours for care staff to provide compassionate, safe and high quality care and support.

The registered manager said, "Domestic staff do care as well. They are trained to the same level as care staff." This provided a contingency in case of staff absence. One relative said, "The staff are trained, they know how to lift and use the rota stand. The physio showed them how to walk with [family member]."

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 so that they can 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 provider had a system in place for monitoring and requesting authorisations to ensure people were not deprived of their liberty without authorisation. Records confirmed these were accurate and correct and conditions were being met.

One staff member explained mental capacity as, "Do they have capacity to make decisions. Do they understand, can they retain information and can they communicate it?" They added, "If they lack capacity we make choices for people in their best interest. We do try to support people to make their own decision, so offering a choice of two things." People told us they made many of their own choices. We observed staff offer choices for activities, meals and when people wished to get up in the morning.

People we spoke with told us the enjoyed the meals at Stichell House. One person said, "Meals are lovely. As long as you let them know you can have anything." Another person said," If there is something you don't like there's no need to go hungry." Another said, "Lunch was beautiful, they cut it up for me, it's lovely." One relative said, "The food is wonderful, always a choice, they will make something different but there's always a choice, they are very accommodating with food. [Family member] has put on a few stone so it must be good!"

The chef was knowledgeable about people's preferences and nutritional requirements. We saw fruit was readily available for people on a dresser in the dining room. On the day we visited the administrator arranged for a mobile ice cream van to attend as it was a sunny day. The majority of people enjoyed the ice cream.

The day's menu was written on a white board in the dining room. Images of the day's menu options were not available to support people living with dementia to make informed choices. We discussed the accessibility for those living with dementia with the registered manager. They said, "It isn't really needed at the minute, we visually show people so they can make a preference. If anyone needed it [a pictorial menu] we would provide it obviously."

The registered manager showed us the tea bars which were available on each floor within the home. The tea bars were a small self-contained kitchen with tea and coffee making facilities available to people's family. The registered manager advised toast, cereal and snacks were also available for people throughout the day.

The dining room was a large open room with large windows which allowed natural light to flood in. The kitchen was attached to the dining room which meant there was quick delivery of meals. There was plenty of space for people to sit comfortably. However, we noted there were not enough tables to accommodate everyone if they all chose to eat in the dining room. The registered manager confirmed that additional tables were available and there was enough space to accommodate all residents and visitors in the dining room. Tables were dressed with a table cloth, napkins, placemats, cutlery, condiments, cup and saucer and beaker.

We observed a relaxed and pleasant atmosphere during the midday meal. It was a social occasion with people enjoying their meal and the company of other people. Although people were advised of the choice earlier in the morning staff offered the choices again to people. Meals arrived immediately and people were asked if they needed anything to go with their meal or if they required a little assistance cutting up an item. One staff member remained in the dining room and was attentive to people's needs. They encouraged people to eat, enquired if people were enjoying their meal and provided continuous cups of tea and coffee. The people we spent lunchtime with were able to eat independently. Some had an assessed need to use specialist equipment and this was readily available for them which meant their independence was supported and maintained.

People and relatives we spoke with told us people were supported with their health care needs. One person said, "They have sorted for me to get my hearing test. I am going today." Another person said, "If I feel off colour they get the doctor they are very good." A relative told us, "They have got all the right people involved." Another relative said, "The doctor comes every fortnight and they send for them straight away if they are concerned. [Family member] sees the nurse, physio and pressure care nurse."

Relatives told us staff contacted them immediately if their relative became ill and they were involved in discussions about health and well-being. The registered manager explained there was a GP clinic once a fortnight in the service. This was used for people to see the GP and for staff to raise any questions or queries they may have. This was an additional service, over and above people having access to the GP they were registered with.

A healthcare professional said about staff, "They are keen for advice and recommendations; they seem to thrive on it they are always keen to ask questions and they demonstrate a good knowledge of people and their needs."

Good

Is the service caring?

Our findings

People told us they were happy living at Stichell House. One person said, "It's absolutely lovely, praise to everyone from the gardener to the manager." Another person told us, "I'm really lucky to be here, excellent staff I can't praise them enough." One relative said, "They have brought my [family member] back to life." Another person said, "There's nothing I can't do here that I did at home."

The home had a relaxed, peaceful atmosphere. Staff were cheerful and engaged with people, sharing in a joke or story. People were included in all conversations, with staff chatting in a respectful and caring way. Staff clearly knew people and their relatives well. They were able to discuss people's likes and dislikes and the important people in their lives. Staff were polite and courteous when speaking to people, giving people time to consider choices and give a reply. No one was rushed to come to a decision.

People were supported to be as independent as possible. We observed staff prompting and encouraging people at meal times. Care staff asked people if they needed support and only intervened at the request of the person. One person told us, "The staff promote independence and that is so important to me." Another person said," I do my best but I know they are there if I need a helping hand."

People and relatives we spoke with told us staff were caring and compassionate. One person told us, "They are as good as gold." Another said, "They look after me well, they care." A relative said, "They don't just care for [family member] they look after me too." One relative said, "They are so good to [family member] and the rest of us, so good to the family." They went on to say, "They took us under their wing straight away. They took us in when we needed help." They added, "We are always made welcome, hello and goodbye, they are like family to me." They also said, "It's very peaceful here, tranquil, rejuvenating, it's lovely, they bring you cups of tea and include us in everything." A duty manager told us, "We support the whole family."

Relatives told us they could visit at any time and they were always made to feel welcome. One relative told us, "I can come anytime." Another said, "The staff are so friendly and welcoming."

People were treated with dignity and respect by staff. One person said, "They are polite and respectful and test the water so it's not too hot." Another said, "They make me feel comfortable." A relative said, "They take time with [family member] and maintain their dignity." One person said, "The laundry service is beautiful, first class. All my clothes and hanky's (handkerchiefs) are all marked for me and they all come back to me."

One staff member told us, "I shut the door, seek permission and explain everything before I do it and make sure I keep the person as covered as possible." We observed staff seek permission before entering people's room and before supporting people. One staff member said, "The residents are the best! They are lovely, you build a rapport with them and the conversations are so lovely."

People were supported to maintain their religious beliefs. We saw a communion service was held weekly.

Stichell House had completed the Gold Standard Framework accreditation. The Gold Standard Framework

aims to improve the quality of care for people near the end of life. A duty manager told us, "I am an end of life champion; I work closely with the Macmillan nurse. We always have a debrief to see if we can do anything better next time."

People were included in decision making around the environment of the home. The registered manager explained that an unused bathroom had been converted into a sitting area for people. They said, "People were involved in the decision to change it. They are such social butterflies that they needed a space to sit together." This room was to be called the butterfly room. We saw residents meetings had involved discussions about the use of the room and how it should be decorated. People had also been involved in decisions around refurbishments in the home.

Where people had no family or personal representative we saw the home provided information about independent advice such as advocacy services. Information was displayed outlining the support available and detailing the local advocacy service. The registered manager advised no-one currently used the service. They stated, "We would support anyone who needed the service."

Stichell House received a certificate and special mention of thanks on the Paul O'Grady radio show for care and support shown by the service and the staff.

Requires Improvement

Is the service responsive?

Our findings

One staff member said, "I write the care plans." We asked if they had received training to do this, they said, "No, but I do write them, learnt along the way." The provider confirmed that the staff member had attended care plan training. Another staff member said, "Yes, I've had training in care plans. I did it with [care services manager] and will help to set up care plans." The provider confirmed that the staff member had attended care plan training. Another staff member said, "Yes, I've had training in care plans. I did it with [care services manager] and will help to set up care plans."

Care records varied in the level of detail and information documented for staff to follow. One person's mobility and falls care plan stated they used a rota stand and needed the support of two staff but there was no detail on how to support the person to use the rota stand. This person's review of care stated they used a handling belt when walking but this was not mentioned in the care plan. Another person needed support with mobility and used a rotary stand for transfers and at times a hoist. The care plan referred staff to 'observe risk assessment and moving handling assessment in relation to safe transfers'. Whilst the moving and handling assessment contained detail in relation to the use of the rotary stand and the moving and handling belt it did not contain detail in relation to the use of the hoist. The moving and handling assessment then referred staff to a moving and handling risk tool which provided detail of the hoist and sling used. This document had not been referred to in the care plan. This meant staff were referred to an additional number of documents before they had the full information required to support the person safely. Risk assessments in relation to moving and handling included risks relating to the use of the handling belt and rotary stand but there was no evidence that the use of the hoist and sling had been risk assessed.

A moving and handling risk assessment tool, completed by an Occupational Therapist, contained specific detail on the use of the hoist and how the person should be transferred. The risk assessment for use of manual handling equipment contained a specific reference for staff to, 'observe risk assessment and moving handling assessment in relation to safe transfers'. The information and detail contained within the risk assessment had not been included in the person's care plan to ensure safe transfers were carried out.

People had continence care plans but they lacked detail of the support products people used. They stated staff should 'make regular checks' but did not specify the frequency of checks. One person's care plan stated, 'night staff will offer more regular pad changes' but there was no detail on the regularity of checks either during the day or at night. This persons care plans detailed that they could be at risk of skin breakdown and had experienced moisture damage however there was no guidance for staff to follow on the frequency to offer support to change continence products in order to minimise the risk of skin damage.

Care plans did not always record people's preferences about the detailed nature of support they required. One person's personal hygiene care plan stated the care intervention as, 'provide a daily wash,' 'offer regular baths or shower,' and 'offer assistance with oral hygiene.' There was no detail on how the person liked to be bathed, the areas in which they were independent or the areas where they needed hands on support or a verbal prompt.

We spoke with the registered manager about this who said, "I see what you mean, they need to be written from the point of view of could I support the person appropriately just by following the care plan." We observed that staff knew people well enough to support them appropriately, however the lack of detail in care plans meant there was not always clear guidance for staff to follow. Care plans contained information which was not always up to date and reflective of people's preferences.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

One person's care records had been developed with the input of the care services manager. These were more detailed and person centred. These included information on the areas where the person was independent and where they needed either physical support such as to wash their back, or prompts, such as to clean their dentures. A relative said, "We were involved in the care plan, involved in anything we want to be." Another person's personal hygiene plan detailed that they enjoyed a shower and a bath and they liked staff to support with beard trimming and shaving.

A document titled, 'Review of Care Manual (6 monthly)' was completed on a six monthly basis and included prompts to discuss the care plans, such as personal hygiene, continence, nutrition, mobility and falls, communication, skin integrity and medicine administration. There was space to record any action to be taken, including referrals to other health care professionals. If a referral was made the date and the person making the referral was noted as well as any comments. We saw people had signed to say they had been included in the review of their care needs.

Care records included information on people's social history and background such as their family and work life, interests, hobbies and important people, places and events. People and their relatives were included in this process and the information was used to get to know people better, and to offer meaningful engagement and activities.

The home employed a full time activities co-ordinator. A relative said, "There's plenty of activities, but we have one another. [Activities coordinator] is very good. [Family member] loves music so we go to music things, or spend time in the garden." Activities included carpet bowls, crafts, bingo, paper sessions, gentle chair exercises, and trips out to the pub, shopping and quizzes. We saw a file containing photographs of social events such as a garden party for the Queen's birthday, Burns night celebrations with a traditional piper, the Somme remembrance, VE day celebrations, as well as birthday and anniversary celebrations. We saw people enjoy a game of 'Play your cards right' and others showed us with delight their manicured nails from the mornings pamper sessions.

People we spoke with were complimentary about the activity co-ordinator's work and their fundraising achievements. One person told us, "Special praise for the activity lady she keeps your mind going." The activities co-ordinator was clearly passionate about their role and said, "I visit every resident and ask what they would like to do." One person said, "I'm a book worm. They leave you alone they don't keep on at you." Another told us about the recent garden party and the band that attended. People told us they had planted potatoes in raised containers and sold them to fundraise. The registered manager also showed us the 'sweet shop' which was run by people in order to fundraise for activities.

The activities co-ordinator was keen to create a sensory room and use their experience in alternative therapies such as reflexology. They told us, "I have made rummage bags with textiles and shapes for one to one sessions. People enjoy head, neck and hand massages."

The home was set in large picturesque grounds which were well-maintained with seating areas available. People enjoyed the views from their own rooms. One person recalled how a squirrel came to their window and tapped on the glass.

We spoke with people and relatives to see if they knew how to complain if the need arose. People and their relatives told us they knew how to raise concerns and complaints but had none. One person said, "I would speak to the manager but I can't complain I love it here." A relative said, "No complaints, not one that I can think of from the domestics to catering to the gardens." A complaints procedure was in place and any complaints that had been received were recorded and investigated appropriately.

Compliments were also recorded and included comments like, 'thank you everyone for the love and care' and 'excellent care provided – I only have praise for the work done, we are fortunate to have such a caring high quality facility.'

The registered manager held regular 'resident and family forums' the last one being in June 2016. Discussion included the Care Quality Commission, the staff restructure and the introduction of duty managers, refurbishment work, GP clinics and quality questionnaires.

Residents' meetings were held on a monthly basis and were well attended. Agenda items included staffing issues with people providing feedback on staff. One comment said, 'staff are very kind and helpful at all times.' Consultation occurred in these meetings in relation to recent refurbishment of a bathroom and the change of use of one bathroom. There was also information shared on health and safety and activities. One comment read, 'A vote of thanks for [activities co-ordinator] for effort to help maintain both mental and physical abilities and also the unseen time spent on fundraising.'

Requires Improvement

Is the service well-led?

Our findings

We looked at the governance procedures for monitoring and improving the quality of the service. The registered manager completed audits however these varied in quality and effectiveness. Care plan audits consisted of a list of documents such as 'all about me', moving and handling assessments, care plans and risk assessments. Next to each item was a tick or a blank, but there was no record of whether the quality and content of the information was accurate, up to date or appropriate.

Monthly monitoring sheets were also completed, which consisted of a list of documents and a tick or initial when audited. We asked the registered manager about audits and they referred to the tick list documents. We saw no content on whether the appropriate quality was met or if any actions were required. Neither of these systems were effective in identifying the concerns in care records noted during this inspection. We spoke with the registered manager about this and they immediately began work to develop a new care plan audit tool. The registered manager explained it was one of the aims of the restructure that the duty managers would spend their 'admin' week working on quality audits to improve care records.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A health and safety audit had been completed and we could see that the action plan had been completed in a timely manner. For example, window restrictor checks had been added to the health and safety check regime. Medicines audits were effective and recorded the content and quality of the audit.

Proprietor's visits were completed every two months. The registered manager said, "The process is they come and do a visit and draft a report, I then respond and take any actions needed." During the June 2016 visit there was feedback from people and staff. The standard of the premises was commented on as, 'Stichell really are to be congratulated on the standard,' this referred to there being no unpleasant odours. There were comments on issues such as safeguarding, complaints, incidents, medicines management and training. The addition of one page profiles into care records was commented on as being a 'great improvement.' There was one suggestion with regard to the additional information on people's spiritual needs. The registered manager had commented that spiritual needs were discussed when people moved into the service and at subsequent intervals. We saw that this was the case.

The care services manager also completed an audit every three months which again included speaking with people, relatives and staff. People were complimentary about the refurbishment work in the tea bars and the decoration of bathrooms and toilets. Family comments included, 'Each person is treated with dignity, respect and as an individual, staff go the extra mile to ensure people live their own lives and on occasions take risks.'

Staff had commented about their involvement in updating care files and that there were some issues in relation to time to do this. This had led to a review of the senior staff complement, including time off rota to concentrate on care records. A full and detailed review of one person's care records had been completed.

This contained a list of actions that needed to be completed in relation to the completion of documents and the quality of information recorded. The registered manager had commented that a full care plan audit had been implemented and a review of the senior care staff complement had been undertaken.

During the following care services manager audit we saw there had been a restructure of staffing and there were now duty managers in post, rather than senior care staff and a deputy manager. This was a recent change, but staff were positive about the changes as it allowed them one week a month were they were not 'on the floor' so they could concentrate on staff supervisions and appraisals, quality audits, care records and developing their roles. The registered manager had recognised that the new structure would support more detailed and comprehensive monitoring to improve quality.

The registered manager said, "We have worked hard to establish a fair, inclusive culture with positive morale. We have a good bunch of staff and interactive team meetings; it's important to say thank you to people."

One relative said, "[Registered manager's] door is always open, so is [Care Services Manager's]. They are brilliant." They added, "[Registered manager] is always available, always there, whether it's something for myself, the family or [family member] they are always there to help." They added, "We know all the staff, they are part of our family." A staff member said, "[Registered manager] is very supportive, always there to speak to, the team leaders are good and so is [care services manager]." One staff member said, "There's support from [registered manager] and duty managers. Their door's always open and they are approachable." They added, "It's a fabulous company to work for. I came and looked around and thought that's where I want to work. It's the location and the friendliness, it's one big family. We really support each other."

A healthcare professional said, "[Registered manager] is available, they make themselves available and communication is effective and responsive." Another visiting professional said, "The home is open and transparent and the manager is receptive to comments / recommendations." They said, "It's one of the best homes." They added, "It's really good, it has improved. It's always been a high standard but things have improved further over the past few years. I think the staff are more confident to raise things appropriately."

Staff meetings were held on a monthly basis and agenda items included health and safety, recruitment, risk assessments, activities and care plans. The registered manager said, "Team meetings are mandatory as attendance was dwindling and staff weren't reading the minutes." Staff said they felt able to add to the agenda and have an open discussion about topics. One staff member said, "We get a thank you in team meetings and supervisions. I've had a voucher before for going above and beyond."

We asked staff if there were any improvements they could think of. One staff member said, "No, no actually. It's one of the best homes. I've never wanted to move, it's got good standards, the gold framework for quality of care." Another staff member said, "No, I can't think of any."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Clear care plans with detailed guidance were not always in place. Care plans did not always include ways in which service users could maintain their independence. The lack of detail in care plans meant they were not always up to date with changes to service users' needs and preferences. Regulation 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A complete and accurate record of each service users care and treatment was not maintained. Systems to assess, monitor and improve the quality of care records were not always effective in identifying where quality was being compromised. Regulation 17(2)(a); 17(2)(c);