Derbyshire County Council

Whitestones Care Home

Inspection Report

139 Manchester Road
Chapel-en-le-Frith
High Peak
Derbyshire
SK23 9TW
Tel: 01629531276
Website: www.derbyshire.gov.uk

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Summary of findings

Overall summary

Whitestones is a care home for up to 41 people. It provides care and support to older people who have dementia. There were 34 people in residence when we undertook our inspection.

The service had a registered manager in post. There were clear management structures offering support and leadership. This meant the home had a positive, empowering culture. Records showed that CQC had been notified, as required by law, of all the incidents in the home that could affect the health, safety and welfare of people.

People told us that they were happy living at the home and they felt the staff understood their care and support needs.

We found that people were involved in decisions about their care and support. Staff made appropriate referrals to other professionals and community services. We saw the staff understood people's care and support needs, were kind and thoughtful towards them, and treated them with respect.

We saw the staff had received training and understood the needs of people with dementia.

There were insufficient staff to meet the needs of people at all times. People were left without staff for long periods and relatives, staff and other visitors told us people using the service had to wait during busy periods. There were not enough staff to keep people safe.

Improvements were required in relation to the recording and auditing of medication to ensure the information was current and up to date to ensure people were properly protected.

People spoke positively about the range of activities in the home and the activities met everyone's individual needs and preferences.

We found that the home was clean, hygienic and well maintained.

Each member of staff received an induction before starting work and core training. The staff had also completed training in areas such as caring for people with dementia and equality and diversity. This meant the staff could meet people's individual needs.

Some people who used the service did not have the ability to make decisions about some parts of their care and support. Staff had an understanding of the systems in place to protect people who could not make decisions about their care, support and safety. These systems followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation sets requirements to ensure that where appropriate decisions are made in people's best interests.

The problems we found breached some areas of the Health and Social Care Regulations. The action we have asked the provider to take can be found at the back of the full report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People were protected from abuse because the staff had received training in how to identify and report possible abuse. The staff were aware of how to report any concerns and safeguarding alerts had been raised by the provider when required.

People who needed a mental capacity assessment or best interest decision had these made by the right people. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant they were aware of how to support people who could not make decisions for themselves.

We looked at the suitability of the environment to ensure people lived in a home where the décor and environmental standards were appropriate. We found the home was clean, safe and well maintained.

Staff handled medicines safely, but better information was needed to ensure staff were clear when to administer as and when required medication.

Risk assessments were up to date and written in a way to support people and protect them from harm.

People using the service, relative's, visitors and staff told us there were not always enough staff on duty to meet their needs. A relative told us that staff did not always respond swiftly to call bells, because they were so busy. They told us they had recently pressed the call bell for their relative who needed urgent help, but no-one came for 20 minutes.

Are services effective?

We saw that people had their needs assessed and staff knew how to support people in caring and sensitive manner. Involvement from advocates could be requested if a person was unable to express their wishes and views.

We saw people's care preferences and choices were sought and met because staff communicated effectively.

People using the service had care records which showed how they wanted to be supported. The information we read in the care records matched the care, support and treatment we saw being delivered to people.

Summary of findings

Are services caring?

People told us the staff were kind, caring and thoughtful. One person told us, "I've always been very satisfied with the care here. It's a good place to be."

People using the service and their relatives told us they did not feel the staff always had the time they needed to give people the support they required in a timely way. One relative told us they had not been able to find a member of staff when their relative needed one. Another relative told us they were frustrated because it was difficult to contact the home by telephone. They said, "I ring up several times on some days and I can't get to speak to anyone. I don't think there can be anybody in the office."

Systems were in place to ensure people's end of life care needs were met in a manner that promoted a dignified, comfortable and pain free death.

Are services responsive to people's needs?

People enjoyed the activities and entertainment offered within the home. We saw these were tailored to meet individual needs and preferences.

The provider listened to complaints and acted upon feedback received from people and their families. This resulted in improvements in care. One relative told us that the home had responded to a recent verbal complaint they had made. They confirmed the complaint was listened to and the situation had improved.

Are services well-led?

The service worked in partnership with other agencies and professionals to make sure people using the service received well managed and well-coordinated care.

The provider needs to ensure suitable systems are in place to provide the necessary numbers of staff to meet people's needs. We spoke with the staff who told us, "I feel rushed; I don't have the time I would like to give to the residents." Another staff member said, "I love my job but feel under intense pressure. Sometimes I feel I cannot do the job to the best of my ability and give people the time they need."

We found the provider notified CQC of any the necessary incidents that occurred in the home. There were good systems in the home to ensure lessons were learnt and improvements were made.

Summary of findings

What people who use the service and those that matter to them say

People using the service who were able to express their views, talked positively about the home. One person told us, “All the staff here are very nice. They’re as good as gold.” Another person said “I’ve always been very satisfied with the care here. It’s a good place to be.”

We found that people using the service received the care they needed from a range of healthcare and social care professionals. We spoke with a nurse practitioner who said, “The home is wonderful. The staff are in tune with people and understand their needs well. The staff are perceptive to relatives and patients.” We also spoke with a visiting consultant who told us, “I have been here three times. I think they are very good. People are considered important, and what makes this place different is they have comprehensive information and involve more people. I would place my mum here.”

We spoke with a relative who said, “I want my mum to stay here, it is brilliant. It is purpose built; they have everything they need and no shared facilities. It is a safe building, just like a giant bungalow, people can move about freely and there’s no smell.” The expert by experience spoke with a relative who said, “They’re good staff, but they are always rushed off their feet. You can’t get to see them as often as you would like.”

Whitestones Care Home

Detailed findings

Background to this inspection

We visited the home on 3 April 2014. This inspection was unannounced which meant the provider and the staff did not know we were coming. The inspection team consisted of two inspectors and an expert by experience. Our expert by experience had experience in dementia care services.

Whitestones Care Home supported older people who may have a dementia related condition. There were 34 people in residence when we undertook our inspection. We spoke with nine people living in the home, seven visitors, four of the staff on duty, two visiting professionals, the registered manager and the service manager.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Through a process called 'pathway tracking,' we looked at three care records, spoke with two staff about the care people received and observed the staff on duty when they provided support. Pathway tracking helps us understand the outcomes and experiences of selected people and the information we gather helps us to make a judgement about the service.

Before our inspection we reviewed all the information we held about the home. This helped us to decide what areas to focus on during our inspection.

At our last inspection in October 2013 we identified problems in relation to staffing levels, medication management and care planning. The provider sent us an action plan in December 2013 telling us how they would address these. We looked at these areas of concern during this inspection to ensure the necessary improvements had been made. We found suitable and sufficient improvements had been made in relation to care planning and medication management. The provider had also increased staffing levels during peak times, but we found these were not sufficient to meet the needs of the people using the service.

Are services safe?

Our findings

We saw the provider had procedures in place for dealing with allegations of abuse. The staff we spoke with had knowledge of the local authority's safeguarding protocols and confirmed they had received training on protecting vulnerable adults and were aware of the different forms of abuse. The staff showed they understood how to identify and report suspicions or allegations of abuse or neglect. Where able, people told us they felt safe in this home One person said "This is my home and I feel very secure here." A visitor told us, "It is brilliant here; I never want my relative to have to move. I know they are safe and well cared for."

We observed care staff managing behaviours that challenged in a sensitive and appropriate way. We saw the person was offered suitable distractions and reassurance, and other people around them were also supported to remain calm and feel safe. Where needed we saw the necessary risk assessments were in place to keep people from harm. The assessments also supported the staff in knowing how to care for the person in a safe and consistent manner.

During our inspection no restrictions were placed on people using the service. People's rights were protected because the staff we spoke with understood the legal requirements that were in place to ensure this. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements. We saw the staff had received training in the Act and the DoLS, and staff told us about the local systems in place to protect people's rights. Advocacy services were available to people if they had no one to speak on their behalf.

At our last inspection we saw medication management needed improvement. On this inspection we looked at the way medicines were managed to check that people were receiving their medicines safely and as prescribed. We saw staff administering medicines at lunchtime in a safe way. We looked at the medication administration records (MAR) to check they had been completed correctly. We saw suitable recording of the medication administration was in place.

We also checked one person's controlled drugs records and saw information was accurate. We checked people's records and found the records and the amount of medication tallied when they were in a blister pack. This meant the provider could be confident the amount of medication recorded was actually available in the home.

We saw the room temperature in the medication storage area was recorded and within the required temperature range. This meant that staff could be certain that medication had been stored as required by the manufacturer.

We looked at the medication records for people who had 'as and when required' (PRN) medication, and saw that protocols were not in place. These need to demonstrate the decision making processes for PRN medication, to validate when and why medicines were administered.

Some people using the service had creams applied and these were recorded on the MAR chart as required. In a number of instances these creams were in bedrooms and not stored securely. The provider needs to be satisfied this is safe practice in relation to people having dementia related conditions.

People were cared for in a safe environment. The home was spacious and accommodated specialist equipment that was required to keep people safe.

Effective systems were not in place to safeguard the health, safety and welfare of people using the service. This meant there had been a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The evidence below describes how this Regulation had been breached.

We sat in one lounge before lunchtime and saw a person fall. Staff were not available and therefore were unaware of the incident. We pressed the call bell for staff to assist as other people in the room did not have the capacity to do this. When the staff arrived they dealt with the person in a kind and caring manner.

We sat in the lounge areas throughout the day and on a number of occasions staff were not available in these areas. After lunch we stayed in one lounge area which was left unattended for 35 minutes. The service manager also sat with us for 15 minutes and was aware of our concern.

Relatives told the expert by experience they could visit any time they wished. One relative said, "I work night shifts so I come in at all hours and I'm always made welcome." Two relatives told us they often had trouble getting into the

Are services safe?

building as there were no staff available to let them in at the front door. Another relative told us they were frustrated because it was difficult to contact the home by telephone. They said, "I ring up several times on some days and I can't get to speak to anyone. I don't think there can be anybody in the office."

Another relative told the expert by experience that staff did not always respond swiftly to call bells, because they were so busy. They told us they had recently pressed the call bell for their relative who needed urgent help, but no-one came for 20 minutes. Another relative visiting the home told us that on Mother's Day they had not seen a member of care staff on duty for three hours.

We observed people receiving their lunch and saw people were asked what they would like to eat and people's wishes were respected. The care staff were spread over four communal dining areas, plus bedrooms. As a result, some people were not receiving the encouragement and support they needed to eat their meal. In one dining area there were no staff in the room for ten minutes whilst people were eating. One person was agitated and needed reassurance, but this was not available when required. We ensured the registered manager was made aware of this at the time.

Are services effective?

(for example, treatment is effective)

Our findings

People using the service and their families felt they were involved in the way they chose to live their lives and their views were listened to and acted upon.

We saw assessments were in place to ensure the provider was able to meet people's needs.

We checked the care records for three people using the service. We saw that the records contained risk assessments specific to the individual's needs. The information in the care records enabled staff to understand the needs of the people they cared for and how to deliver care in a way which met those needs. One member of staff told us, "We work well as a team and know people well."

We looked at the support people received in relation to their nutritional needs. We saw the records were informative and completed as required. We saw that on admission nutritional screening tools had been used to assess the support required. Where necessary, referrals had been made to the speech and language therapist to ensure suitable aids and adaptations were available. At lunchtime we saw plate guards and other aids were used to encourage and support people with their eating and drinking.

We saw records that showed where people had visited health professionals including doctors, dieticians and chiropodists. People were visited by an appointed nurse twice a week to ensure consistency of care, treatment and support. This meant that people were supported to maintain their health and wellbeing. The appointed nurse told us, "My visits have meant a reduction in the number of hospital admissions and out of hours call outs. It means I know people here well and can easily judge if there is an improvement or a decline in their health."

Staff confirmed they received the training they required and felt they worked well as a team. One staff member said, "The training is very good and we get good information about the people who live here." They were trained to provide the specialist care that people required. Examples of subjects covered during this training included; care planning, consent, moving and handling and dementia care. Staff also completed competency based assessments to ensure that they could demonstrate the required knowledge and skills in areas such as medication administration.

Are services caring?

Our findings

The staff were friendly and professional in their approach and interacted confidently with people. We observed the staff as they supported the people they cared for. We saw that there was a relaxed atmosphere in the home and people were comfortable with the staff. We saw staff treating people with compassion and listening to people's wishes. The staff told us that they always made sure they treated people respectfully and that their privacy was protected when they provided support.

We saw the staff recognised individual differences and treated people in a way that met their diverse needs. For example some people stayed in their bedrooms and didn't join in group activities whilst others did, and chose to attend religious services, either within the home or at the local church.

We spoke with the nurse practitioner in relation to how the provider managed end of life care. They told us the home had worked in a sensitive and compassionate manner in relation to this. They said, "I was blown away by the staff. They cared so well for a very frail person who was bed bound. I don't know how they kept them free of pressure sores. They were beautifully nursed. The do not attempt resuscitation was in place under full agreement and the person was tucked up in bed and died peacefully, the staff were with them. It was a planned death and they died with dignity." We saw the staff were familiar with the communication needs of the people they supported. We saw they took time to make sure people understood and always explained what support they were about to provide. People were offered a choice of drinks, where to sit, and were encouraged and supported to move freely around the home This meant the staff had a clear understanding of how to meet each person's needs in a caring and consistent way.

We spoke with a visiting professional who said, "I see consistent staff who are perceptive and know how to treat people as individuals. They are knowledgeable, attentive and kind."

Where people had behaviours that challenged we saw the staff dealt with these in a professional and appropriate way. Suitable action was taken to support and enable people using the service. People were spoken with in a calm, kind, dignified and adult manner.

We spoke with the staff who were able to give us examples of treating people in a compassionate manner. One member of staff said, "We are sensitive to people's needs and always make sure the doors are closed and we knock before entering. We talk about likes and dislikes and we know how people like to be addressed."

People using the service and their relatives considered they were listened to. One person said, "You only have to ask and they will help if they can." We observed staff speaking courteously to people and reassuring them when giving assistance. People told us they chose what to wear and when requested were dressed in co-ordinated clothes. The hairdresser was working on the day of our inspection in a well-equipped and purpose built room. Several people told us they enjoyed their hairdressing sessions.

People seemed relaxed in the company of staff and there was affection in many of the social exchanges we observed between people who lived at the home and the staff. One person said "I like it here. The people are nice and friendly."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Two activity co-ordinators provided activity sessions over seven days. On the day of our inspection there was a church service in the morning and one activity session timetabled for the afternoon. The expert by experience saw this session offered individual engagement with people to encourage them to join in the Grand National event at the weekend. We also observed the activities co-ordinator speaking with people in their bedrooms to ensure everyone was able to participate. People we spoke with told us external entertainment was provided, such as musical sessions and a magician. Relatives said they had seen activities taking place during the day and evening. One person said, "They make sure people are supported to engage in activities. I have noticed this makes people calmer and more relaxed."

The care records we viewed showed that where people needed specialist advice or treatment, the provider had liaised with the appropriate agencies. We saw that people who required equipment to manage pressure care had been suitably referred. We saw where people had nutritional needs, their GP had been informed. This meant that people using the service were supported to access appropriate health and social care support to meet their needs.

During our inspection we saw that staff gained verbal consent from people using the service for their day to day care. People were asked where they wished to sit and what they wanted to do. People confirmed that the staff asked their permission before supporting them to do something.

We saw two care records had information that the person using the service should not be resuscitated, this is known as a do not attempt to resuscitate (DNAR). We spoke with two staff who knew this information was recorded and they told us one person did not have capacity to make this decision. A mental capacity assessment had been completed to record how the decision had been reached, and why this decision had been made in the person's best interest. We saw the GP and family members had been involved in the reviews. There was a lack of evidence available to determine whether other people could make the decision on someone else's behalf through a lasting power of attorney (LPA). This gives someone the authority to make decisions. This meant people may not have the legal authority to make those decisions on the person's behalf.

We spoke with two staff who told us they had received training for the Mental Capacity Act 2005. We discussed the implications of the Act in relation to capacity and consent, as although staff had received training in this area we wanted to ensure the staff knew the principles of the Act. The staff we spoke with were able to explain this, which demonstrated people could be confident their wishes would be taken in to account where they no longer had capacity.

We reviewed the complaints procedure that was in place. This stated how people could complain, who they could complain to and when any complaint would be responded to. This procedure was available in different formats, including the use of pictures and photographs to support people's understanding. One relative told us that the home had responded to a recent verbal complaint they had made. They confirmed the complaint was listened to and the situation had improved. This meant it was accessible to people and they were aware of their right to complain.

Are services well-led?

Our findings

Staff understood their right to share any concerns about the care at the home. All the staff we spoke with were aware of the provider's whistleblowing policy and they told us they would confidently report any concerns in accordance with the policy.

One person using the service told us, "You can talk to any of the staff and they listen to you."

We saw documents such as comments, complaints and compliments were used to gather information about how well the service was performing.

There was a clear management structure at the home. The staff we spoke with were aware of the roles of the management team and they told us that senior managers were approachable and had a regular presence. During our inspection we spoke with the registered manager and the service manager. Both demonstrated they had an understanding of the care provided which showed they had regular contact with the staff and the people using the service.

Satisfaction surveys were sent to people using the service. We saw these were also available to people who used the service on a respite basis. We saw these were evaluated and changes made where needed. We saw the tea room had been introduced following the evaluation of information offered. This meant there were systems in place to ensure people had a way of providing feedback.

We saw the care records were reviewed on a monthly basis to ensure that staff had the correct and up to date information to meet people's needs. We saw that health and safety checks were also being carried out regularly to keep people safe.

We saw regular audits took place on falls, accidents and incidents and infection control. We saw action plans were in place to ensure issues were dealt with appropriately. This meant the provider ensured improvements were made to improve the care and support delivered.

We talked to staff about how they would raise concerns about risks to people and poor practice in the service. Staff told us they were aware of the whistleblowing procedure and they wouldn't hesitate to report any concerns they had about care practices. This was discussed in team meetings and supervision. This meant staff were aware of the action to be taken to protect people using the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** People's health, safety and welfare, were not fully safeguarded because sufficient numbers of suitably qualified, skilled and experienced care staff were not always provided.