Landona House Limited

Stapleton House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Stapleton House is a care home that provides nursing and personal care to a maximum of 45 older people, including people who live with dementia or a dementia related condition. At the time of inspection there were 31 people who were using the service

At the last inspection in August 2015 we had rated the service as good. At this inspection we found the service remained good and met each of the fundamental standards we inspected.

People told us they were well looked after and they appeared content and relaxed with the staff who supported them. Relatives told us they were satisfied with the service provided by Stapleton House staff. Staff knew the people they were supporting well.

People said they felt safe and they could speak to staff as they were approachable. We have made a recommendation about staffing levels to be kept under review and that staff are appropriately deployed to ensure people's needs are met safely. We observed activities were not always available to keep some people engaged and stimulated in some areas of the home where staff were not always available. Improvements were required to some aspects of people's dining experience in this part of the home.

Systems were in place for people to receive their medicines in a safe way. Risk assessments accurately identified current risks to the person, as well as ways for staff to minimise or appropriately manage these risks.

Staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Detailed records accurately reflected the care provided by staff. Care was provided with kindness and people's privacy and dignity were respected. Communication was effective in ensuring staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received a varied and balanced diet to meet their nutritional needs.

A complaints procedure was available. Staff and relatives said the management team were approachable. People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. People had access to an advocate if required. The home had a quality assurance programme to check the quality of care provided.

Changes had been made to the environment as a programme of refurbishment was taking place. Some areas that we identified at inspection for more immediate attention were dealt with straight away. The home promoted the orientation and independence of people who lived with dementia and further work was taking place as part of the refurbishment.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service deteriorated to requires improvement.

We have made a recommendation that staffing levels are kept under review and that staff are appropriately deployed to meet people's needs safely.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Stapleton 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 checked 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 3 October 2017 and was unannounced. We received further evidence as part of the inspection on 11 October 2017. The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

During the inspection we spoke with 11 people who lived at Stapleton House, six relatives, the provider, the registered manager, one activities co-ordinator, five support workers, one visiting support worker, one member of catering staff and one visiting health care professional. After the inspection we spoke with one health care professional who visited the home. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with said that they felt safe living at Stapleton House and were well supported by staff. One person told us, "I am safe here, I wouldn't be here if I wasn't. The other day I was upset and one of the staff came over and talked to me and calmed me down." Another person commented, "I feel quite safe here because there are people around me and I can press the buzzer if I need anything and they [staff] usually come quite quickly." A third person said, "I feel safe here and my wife makes sure I'm safe." One relative commented, "[Name] is quite safe here." Another relative commented, "There is always someone popping in and out to make sure [Name] is okay." A third relative said, "[Name] is well-looked after, I have no worries."

There were 31 people living at the home at the time of inspection. Staffing rosters and observations showed on the first floor 16 people, most of whom lived with dementia, were supported by three support workers including one senior support worker.

We considered staffing levels on the ground floor required reviewing to ensure there were sufficient staff on duty at all times and who were appropriately deployed so people were kept safe.

We observed on the ground floor 15 people some with nursing needs were supported by one registered nurse and initially two support workers until 11:30am when a third support worker came on duty. We were told by the registered manager there were usually three support workers on duty from 8:00am until 8:00pm however, a third staff member was not available until 11:30am to replace a staff member who was unavailable to work.

On the ground floor three people were cared for in bed due to their health care needs. Seven people required two members of staff for their moving and assisting needs. We were told ten of the people required total assistance with all their needs and this included five people who needed total assistance to eat as well as other people who were at risk of falling. This meant when staff were busy other people had to wait and were left unsupervised. In the afternoon, people sitting in the lounge were left unsupervised and we observed one person, who was at risk of falls, had slid from their chair to the floor.

At other times of day staff were busy on the ground floor and did not have time to spend with people in their bedrooms except when they carried out care. We considered the lunch time meal and tea time meal required better organisation including staff deployment as we observed at the lunchtime one person was left waiting in the dining room on their own for over 30 minutes as staff were busy with other people. At tea time staff were not available to support the people as they ate their buffet in the lounge. We intervened as well as a relative as staff were not present as they were busy in other areas.

We discussed these observations with the provider who told us a staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. They also told us the registered nurse also provided direct care to people on the ground floor.

We recommend that staffing levels are kept under review to ensure people receive safe care that meets their needs.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. One member of staff told us, "I've done local authority safeguarding training." All staff expressed confidence that the management team would respond to and address any concerns appropriately. One staff member told us, "If I had any concerns I'd report it straight away to the senior or management." Another staff member told us if they saw any unexplained bruising on a person, "I'd report it, document it and body map it."

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Risk assessments were recorded in people's care records. The documents were individualised and provided staff with a clear description of any identified risk. There was specific guidance on how people should be supported in relation to the identified risk for example, from falls or risk of choking. Where an accident or incident did take place these were reviewed by the registered manager or another senior staff member to ensure that any learning was carried forward.

There were appropriate emergency evacuation procedures in place, regular fire drills had been completed and all fire extinguishers had been regularly serviced. An up to date fire risk assessment was in place for the building. A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was in case the building needed to be evacuated in an emergency. All lifting equipment within the home had been regularly tested and serviced. All electrical equipment had been tested to ensure its effective operation. Arrangements were in place for the on-going maintenance of the building and a maintenance person was employed.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. One person told us, "I get my tablets when I should." All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed.

Staff personnel files showed that a robust recruitment system was in place. This helped to ensure only suitable people were employed to care for vulnerable adults. Staff confirmed that checks had been carried out before they began to work with people.

Good

Is the service effective?

Our findings

The staff training records showed and staff told us they had received training to meet people's needs and training in safe working practices. One staff member told us, "There's plenty of training." Another member of staff said, "Training is on-going. " A third staff member commented, "There is in-house training and I'm also doing an external training course." There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. The training gave staff some insight into people's needs and this included a range of courses such as dementia care, equality and diversity, risk assessment, nutrition, skin care, communication, recording, distressed behaviours, end of life care and nursing competency refresher training.

Records showed that staff received induction, supervision and appraisal. This allowed new staff to be supported into their role, as well as for existing staff to continually develop their skills. New staff had undergone an induction programme when they started work with the service which included shadowing more experienced workers until they were confident in their role. Staff told us they could access day to day as well as formal supervision and advice and were encouraged to maintain and develop their skills. One staff member told us, "I have supervision every two months."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We found as a result, that 27 people were currently subject to such restrictions.

The service worked within the principles of the MCA and trained staff to understand the implications for their practice. Consent was obtained from people in relation to different aspects of their care, with clear records confirming how the person had demonstrated their understanding. Mental capacity assessments had been carried out, leading to decisions being made in people's best interests.

The home was being refurbished and several communal areas had been decorated. We discussed with the provider some areas that required more immediate attention. We received evidence that showed these improvements were made straight after the inspection. The top floor lounge was designed to ensure it was stimulating and therapeutic for the benefit of people who lived there. We advised that the hallways could have themed areas and sitting areas to stimulate and remind people as they sat or walked around. Visual stimulation such as a pictorial activities board would also help maintain the involvement and orientation of

people with dementia. The registered manager told us that this was to be addressed as part of the refurbishment. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms had signs for people to identify the room to help maintain their independence.

People enjoyed a varied diet. They were offered regular drinks and snacks throughout the day in addition to the main meal. One person said, "The food is nice and there's enough of it." Another person commented, "I am really quite happy with the food I get." One relative told us, "I sometimes stay for lunch at the weekend and its lovely." A visiting professional commented, "[Name]'s food is all pureed but its set out separately and not put all together so it looks much better."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Food and fluid charts recorded people's nutritional and fluid intake. However, food charts did not accurately record the amount that people had eaten as some charts stated 'ate all' or 'ate half.' This did not show the amount of food that had been served to the person to provide accurate monitoring of their nutritional intake. We discussed this with the registered manager who told us it would be addressed.

People were supported to access community health services to have their healthcare needs met. Their care records showed they had input from a range of different health professionals. For example, the GP, dietician and the speech and language therapy team (SALT). People also had access to dental treatment and optical services. Relatives told us they were kept informed about their family member's health and the care they received. One relative commented, "Communication is good with staff, they keep me up-to-date about [Name]." A fortnightly clinic took place at the home run by the GP from a local surgery and supported by a nurse from the home. The clinic was held to review people's health needs and their medicines and make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

Good

Is the service caring?

Our findings

During the inspection there was a pleasant atmosphere in the home. Staff interacted well with people. People appeared calm and relaxed as they were supported by staff. Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with all said staff were kind, caring and patient. One person told us, "It's lovely here, everyone is friendly. It's just what you want." Another person commented, "Everything is nice." A third person said, "I'm happy, the staff are lovely and caring and my family can visit any time." Other people's comments included, "They're nice people here, friendly and helpful", "Staff are lovely, although we could do with some more", "My room is kept lovely" and "Staff are very kind and nice." A relative told us, "[Name] is fine, they're well-cared for." A visiting professional commented, "[Name] has settled in quickly."

Staff took time to listen and observe people's verbal communication. Care plans described how the person communicated and when they may show signs of distress, so staff were able to provide appropriate support and guidance to the person to reassure them. For example, one care plan recorded, '[Name] can communicate their needs but requires time. Speaks in a quiet tone.' Guidance was available which documented how people communicated, when they may no longer be able to express their wishes and needs verbally. For example, how they may show they were in pain if they were unable to tell staff verbally that they were in pain or distressed. One communication care plan stated, '[Name] is able to alert staff if they are in pain.'

Care was provided in a flexible way to meet people's individual preferences. People told us they made their own choices over their daily lifestyle. For instance, people had the opportunity to have a lie-in. They told us they could go to bed when they wanted and staff respected their wishes. One person told us, "I can get up and go to bed when I want and I can choose to have breakfast in my room." We heard staff ask people for permission before supporting them, for example with personal care or offering them protective clothing at the lunch time meal. One person told us, "Staff ask if you want something. They don't just give it to you."

Staff treated people with dignity and respect. We observed good practice throughout the inspection. Staff members knocked before entering people's rooms, including when doors were open. One person told us, "They [staff] always shout your name or knock on the door before they come in." Staff were discreet when speaking to people about their care and treatment. People looked clean, tidy and well presented. One relative commented, "[Name] is always clean and their room is clean." Another relative said, "[Name] is clean and their hair is always nice."

We observed the lunch time meal. In the top floor dining room lunch time was a social occasion. Soothing music was played that promoted a calm atmosphere and encouraged people to eat. Staff were supportive to people and offered full assistance or encouragement and prompts as required. Food looked appetising and was plentiful and hot and cold drinks were served. We considered improvements were required to the organisation of people's dining experience on the ground floor due to the deployment of staff. People did not all sit down to their meal at the same time. The atmosphere was quiet, people were served in the dining room by the cook and they sat silently. Support staff were not always around to assist or encourage people

as they were busy elsewhere.

Pictorial menus were available to help inform people about the food. People sat at tables that were set with tablecloths but napkins and condiments were not available. Some people remained in their bedrooms to eat. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. The meal time organisation was discussed with the registered manager who told us it would be addressed immediately.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed their wishes in relation to resuscitation. A 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive was in place for some people. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. One person told us, "I've been to Beamish." Another person said, "We can play bingo." A relative told us, "[Name] likes to stay in their room and they're not forced to join in anything." An activities organiser was employed who was very enthusiastic about their role. They told us activities were planned according to the interests of people. An activities programme was designed and incorporated these interests to make activities more meaningful to people. Records showed there were weekly trips out into the community, gardening projects planting fruit and vegetables, hanging baskets and tubs. Themed cuisine nights took place that included Indian and Mexican nights. Other activities included baking, arts and crafts, music, crosswords, dominoes and newspaper discussions.

We observed on the top floor there was a lively and busy atmosphere. People who lived with dementia were stimulated and were offered individual and group activities during the day. Some people sat with sensory and tactile blankets which kept them engaged as they felt them and listened to the different sounds they made. Other people played dominoes or did jigsaws after watching a musical film on the television. Most people sat in communal areas and staff were available to supervise and engage with people. On the ground floor however, there was a different atmosphere and we did not observe activities taking place or this level of staff interaction or supervision. Several people on the ground floor chose to remain in their rooms and the few people who were in the communal lounge sat on their own and did not appear stimulated or engaged whilst the television was playing. We discussed this with the registered manager who told us it would be addressed.

There was a good standard of record keeping. Before people used the service, they received information about the home and an initial assessment was completed to ensure the service could meet their needs.

We spoke with a visiting support worker, from the service of a person who had been recently admitted. They were working temporarily at Stapleton House to support the person to settle in. They were very positive about how the person had settled in and told us the person had become more independent with regard to their moving and assisting needs. They commented, "[Name] needed to be hoisted when they first came here but now they can self-support. There used to be some distressed behaviours but there have been none here."

Records showed pre-admission information had been provided by relatives of people who were to use the service and other professionals. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, behaviour support, mobility and communication needs.

Care plans were detailed and provided information to staff about how the person needed to be supported and what they could do to maintain their independence. People's care records were kept under review. One person told us, "I'm fully involved in my care plans and reviews and I'm as independent as I can be." Monthly

evaluations were undertaken by care staff and care plans were updated following any change in a person's needs. A daily record was available for each person. It was individual and in sufficient detail to record their daily routine and progress in order to monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their current needs and preferences.

People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. Examples in people's records included, '[Name] likes to retire at 7:00pm and get up at 7:00am', '[Name] likes to listen to 1950's music' and 'Likes to wear slippers indoors.' Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends.

People using the service and their relatives told us they knew how to complain if they needed to and expressed confidence that issues would be resolved. Most said they would speak to the registered manager or a senior member of staff if they had any concerns. A copy of the complaints procedure was clearly available in the hallway. A record of complaints was maintained and 12 complaints had been received and resolved since June 2016.

People and their relatives were kept involved and consulted about the running of the service. Regular meetings took place with people who used the service and minutes were available for people who were unable to attend.

Good

Is the service well-led?

Our findings

A registered manager was in post who had registered with the Care Quality Commission in October 2014. A registered manager is a person who has registered with CQC 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.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and staff were open to working with us in a co-operative and transparent way.

The atmosphere in the home was friendly. The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were positive about their management and had respect for them. They told us the service was well led. They said they could speak to the registered manager if they had any issues or concerns. One staff member told us, "[Name] the registered manager is very approachable." Another member of staff commented, "The manager is approachable. They try to do what they can."

Communication was effective within the home. Staff were kept up-to-date about the running of the home. People's needs were discussed and communicated at handover sessions when all staff changed duty, at the beginning and end of each shift. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. This was so staff were aware of risks and the current state of health and well-being of people. One staff member told us, "We have a handover every morning when we come on duty."

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings. One staff member told us, "We have monthly staff meetings." Another staff member commented, "We have regular staff meetings." A third member of staff said, "We have separate meetings for senior staff as well."

The registered manager told us they were well supported by the provider. They had regular contact with them, ensuring there was on-going communication about the running of the home. Regular meetings were held where the management were appraised of and discussed the operation and development of the home.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who lived in the home. The audits consisted of a wide range of weekly, monthly, quarterly and annual checks. They included the environment, health and safety, accidents and incidents, complaints, personnel documentation and care documentation. Audits identified actions that needed to be taken. Audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. A monthly risk monitoring report that included areas of care such as accidents,

incidents, safeguardings, complaints and personnel issues was completed by the registered manager and submitted to the provider for analysis.

Monthly visits were carried out by the provider who would observe and speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

We discussed with the provider and registered manager the impact of staffing levels and staff deployment on the ground floor. This included people's dining experience and limited activities provision. We were told by both that this would be addressed.