Stratfield Lodge Limited

Stratfield Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. During the visit, we spoke with four people, four staff, the home manager (who manages the home on a day to day basis), the registered manager and the representatives of the provider. The registered manager and the representatives of the provider are a family. As part of the inspection we also sought the views of four relatives and health and social care professionals.

Summary of findings

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

Stratfield Lodge Residential Home provides accommodation and personal care for 17 people who have learning disabilities, mental health and/or dementia care needs. At the time of the inspection there were 17 people living at the home.

Some of the people who lived at the home had complex needs and were not able to tell us their experiences. We saw that those people and the people we spoke with were smiling, happy and relaxed in the home.

People told us they felt safe at the home. Staff knew how to recognise any signs of abuse. However, they had not made a safeguarding referral as they should have when someone had received poor nursing care in another health setting.

We saw people received care and support in a personalised way. Staff knew people well and understood their needs. We found that people received the health, personal and social care and support they needed.

However, we found that one person's received the care they needed and staff knew how to care for them but there was not a written plan on how to care for this person.

We found that staff were caring and treated people with dignity and respect. People had access to the local community and had individual activities provided.

Staff received an induction, core training and some specialist training so they had the skills and knowledge to meet people's needs.

People, staff, relatives and professionals commented on the friendly and family atmosphere at the home. One person said: "I'm so happy here. I go out with staff and the owner; there is not one member of staff that I don't like". A relative told us: "I have total confidence in them, I like that it is family run". There was a person centred culture at the home with a focus on people being involved in all aspects of the home. There was a clear management structure and staff, representatives and people felt comfortable talking to the managers about any concerns and ideas for improvements. There were systems in place to monitor the safety and quality of the service provided.

Summary of findings

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 home was safe we but we found some improvements were needed. This was because although staff knew how to recognise abuse within the home and how to report it, they had not made a safeguarding alert about another service as they should have done. Decisions that were made in people's best interests were not always recorded as they should have been.

People, staff, relatives and professionals told us there were enough staff to keep them safe. We found staff were safely recruited.

We found that any risks to people were managed so they were kept safe.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. The home manager had made applications that needed to be made.

Is the service effective?

Requires Improvement

The home was not consistently effective and we found some improvements were needed. This was because although staff had provided the correct care to one person they had not reassessed and planned their care following their readmission into the home. However, most people's assessments and care plans described the care and support provided by staff.

The staff had effective training and support to carry out their roles. People, their relatives and professionals felt staff were skilled and knowledgeable in meeting their needs.

People enjoyed the care home's food and had a choice about what and where to eat. People's specialist diets and needs were catered for.

Is the service caring?

Good

The home was caring. The people and their relatives told us that staff were kind, caring and compassionate.

People were involved in decisions about the support they received and their independence was respected.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Good

The home was responsive to people and their needs.

Staff understood people's complex ways of communicating and responded to their verbal and non-verbal communication and gestures.

People were supported to pursue activities and interests that were important to them.

Summary of findings

People and their relatives knew how to complain or raise concerns at the home.

Is the service well-led?

Good

The home was well-led. Observations and feedback from staff, relatives and professionals showed us the home had a positive and open culture.

The management team had arrangements in place to assess and monitor that there were enough staff, with the right skills, knowledge and experience to meet the needs of people.

There were systems in place to monitor the safety and quality of the home. There were robust systems in place for the maintenance of the building and equipment.

Stratfield Lodge Residential Home

Detailed findings

Background to this inspection

One inspector visited the home on 9 July 2014 and we spoke with four people, four staff, the home manager (who manages the home on a day to day basis), the registered manager and the representative of the provider. We sought the views of two relatives by telephone and one by email. We observed care and support in communal areas and also looked at the kitchen and five people's bedrooms. We looked at three people's care records in detail to track the care and support they received. We also looked at some care records for one other person and a range of documents about and how the home was managed.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. We reviewed this and other information we held about the home such as information about incidents they had made to us. We also contacted six health and social care professionals who work with the home to obtain their views. As part of the inspection we asked the home manager to send us information following the inspection about the staff training and the training plan.

We used 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 talk with us.

We inspected Stratfield Lodge Residential Home in January 2014 and found the home had met the standards we inspected.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

We spoke with people and observed people in communal areas. Two people were able to tell us that they felt safe at Stratfield Lodge. One person said: "I feel so safe, they understand about my condition". We saw that other people freely approached and sought out staff. They smiled and responded positively when staff spoke with them. This indicated they felt comfortable and safe with staff. Two relatives told us they felt their family members were safe at Stratfield Lodge. One relative said: "He's safe there it gives me peace of mind".

There were posters displayed in the communal and staff areas about how people and staff could report any allegations of abuse. All of the staff had received safeguarding training as part of their induction and ongoing training. All of the staff we spoke with were confident of the types of the abuse and how to report any allegations. However, we found the home or registered manager had not raised a safeguarding alert about the poor physical condition of one person. This person had been discharged from a hospital back to the home with a number of pressure sores and a cannula (a small tube in the vein for giving fluids or medicines) left in their hand. We discussed this with the home manager and they acknowledged that they should have made the alert to make sure that concerns about the hospital were raised and that other vulnerable people were protected. This was an area for improvement and the home manager took immediate action and raised a safeguarding alert with the local authority during the inspection. We found the home manager had taken action to ensure the person received the correct care and treatment from district nurses and the out of hours GP on their return to the home.

People had risk assessments and plans in place for; pressure areas, nutrition, falls, and access to the community, behaviours and epilepsy management. For example, we saw there were behaviour management plans in place for people who needed them. We spoke with staff who were clear about the strategies to reassure people and manage any behaviours that presented challenges to themselves and others.

There were clear epilepsy risk management plans in place for those people with epilepsy. The staff we spoke with knew what action to take in response to each individual having a seizure. This reflected the epilepsy care plan in place.

All of the staff had been trained in Deprivation of Liberty Safeguards and the four staff we spoke with were knowledgeable about this and the Mental Capacity Act. They gave us examples of where they made decisions in people's best interests, such as making decisions in relation to the administration of medicines where people did not have the mental capacity to consent to taking medicines.

Overall, best interest decisions were made following mental capacity act assessments by professionals. For example, one person had a best interest behaviour management plan in place, written with the person's community learning disability nurse, in relation to their reluctance to receive personal care. This plan included using a safe holding technique as a last resort if all of the other strategies such as changing the staff over, leaving the person for a period of time and using pictures to explain to the person did not reassure them so that staff could provide their personal care. The home manager told us that this holding technique had only been used twice and each incident had been fully reported and reviewed with the professionals involved to make sure that it had been used appropriately.

Two people, whose care we tracked, had bed rails in use to minimise the risks of them falling out of bed and there were risk assessments in place about this. However, these individuals were not able to give their consent and there was not a best interest decision recorded where there should have been. We identified this as an area for improvement and the home manager told us they had also identified this as something that they needed to work on.

The home was meeting the requirements of the Deprivation of Liberty Safeguards. The home manager was making the applications that needed to be made. They had agreed with the local authority to submit these applications one at a time. This was because the local authority did not have the capacity to assess the large numbers that were being applied for.

We looked at the staffing rotas for a four week period, spoke with people and staff and they told us there were

Requires Improvement

Is the service safe?

enough staff to meet people's needs. We saw that people received the care and support they needed without waiting. Staff responded to people's verbal and non-verbal requests and call bells quickly. The representative of the provider and registered manager told us they calculated staffing levels according to people's needs and that if people's needs changed they increased staffing levels. For example, following the last staff meeting staff had identified that not having activities staff working at the weekends was having an impact on people as they did not have the same access to activities and the community at the weekend as they did during the week. The provider took action and activities staff were asked to work weekends as well as during the week.

We looked at four staff recruitment records and spoke with one member of staff about their own recruitment. We found that recruitment practices were safe and that the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

Medicines management at the home was safe. We saw staff had received training in medication administration and had a yearly refresher. The home manager told us that they had their competency assessed following completion of their training.

We looked at the medicines storage and found that controlled medicines and other medicines were stored safely. We checked the controlled medicines in use and saw that the stock and administration records tallied. This showed us the systems for checking and administering controlled medicines were safe. We saw from Medication Administration Records (MAR) that medicines were administered as prescribed. One person told us: "Staff help me with my tablets and draw up my insulin so I can inject myself". Staff told us they had received training from the District Nurses to draw up this person's insulin so they could inject themselves.

We looked at the medication plans for four people living at the home. Some of the people living at the home had complex health and communication needs and they were not able to tell staff when they needed medicines such as 'as required' pain relief or if they were very upset or anxious. There were PRN (as required) plans in place that included clear descriptions of how people presented when they needed any 'as required' medicines. We spoke with staff who confirmed they had clear information as to when they needed to administer 'as required' medication, the frequency of the dose and the maximum dose in 24 hours.

The home manager showed us the monthly medicines audits in place. We saw that where any omissions in recording or administration that these were followed up with staff members and immediate action was taken to contact health professionals.

Requires Improvement

Is the service effective?

Our findings

Two people who were able to tell us said they were looked after if they were unwell. One person said: "if you're not well they look after you. One day I was sick everywhere, they did it all in a nice way". Another person said: "They understand about my condition and don't just leave me alone. They come and sit with me and reassure me".

People had access to specialist health care professionals, such as physiotherapists, community mental health nurses, dieticians, occupational therapists, speech and language therapists and specialist consultants. For example, one person had recently been diagnosed with a specific condition. The home manager had ensured that the specialist nurse had visited the home to give the individual and staff information and training about the disease.

Before our inspection, we asked health and social care professionals for their opinion of the home, and they gave us positive feedback. One health care professional wrote to us: 'I have found all staff to be professional in their approach, have noted that they are fully aware of their client's needs, will go 'the extra mile' to meet those and have excellent working relationships with these clients.'

We looked at the care records for one person who had complex learning and physical disabilities and who was also living with dementia. This person had recently been discharged from hospital back to the home with numerous pressure sores. We saw from records and from talking with staff that appropriate action had been taken, the district nurses were involved and the person had received the care and treatment they required. Staff told us and records showed us the person had been repositioned every three hours, had bed rest and had a specialist air mattress and cushion. The person's pressure areas had nearly healed but there was not a written pressure area care plan in place to instruct staff how to provide this care. This was an area for improvement and the home manager acknowledged this and agreed to put the written plan in place.

This person had a catheter and two staff described in detail the catheter care they provided to the individual but there was not a catheter care plan in place to instruct staff how to provide this care. We saw staff had been keeping a detailed record of the individual's fluid intake and catheter output. The records showed the person was having over 1500 ml a fluid a day. However, we noted that there was not target amount of fluid so that staff could assess whether the person had had enough to drink. From discussions with staff and from daily and other monitoring records we saw the person had received the care, treatment, nutrition and fluids they needed. However, their additional pressure area care, nutritional and catheter care needs had not been reassessed and planned for when the returned to the home from the hospital. This meant that potentially staff would not have had the information about how to provide the person with the right care. Following the inspection the home manager sent us catheter care plan for the person which also included a target amount of fluid of 1500 ml so staff could assess when adding up the person's fluid intake if they had enough to drink.

The home manager showed us that the recording for each person was based on their specific needs. For example, one person who was supported by one member of staff had a record template for staff to record every hour what the person had been doing and how they had been. Another person's records had specific sections for them to record whether they had been in a positive or negative mood. This was so the home and professionals were able to assess whether the way the staff were supporting the individual was effective.

We saw that the three people had a health action plan completed; this was a plan about how people could keep healthy and who they needed to see to do this. We saw there were detailed records for each person of health appointments and telephone contacts from health and social care professionals. People had also been provided with health books from the learning disability nurse. These books were supported by pictures and included important information about an individual and their health. However, the home manager told us that health professionals were not yet using these books so Stratfield Lodge was keeping detailed records to be able to evidence that people's health needs were being met.

We saw that photographic and pictorial signage was used throughout the home to identify specific rooms. Different coloured toilet seats were used so people living with dementia could easily see the toilet. Each person had chosen the colour of their bedroom door and picture of something that was important to them so they could easily identify their bedroom.

People's nutritional needs were assessed, monitored and planned for. People were weighed monthly and action was

Is the service effective?

taken if people's weight changed significantly. For example, one person was referred to the dietician when they had lost weight and they had a low BMI (Body Mass Index). People who were identified as nutritionally at risk received fortified diets and nutritional supplements and we saw that these individual's weight had remained stable or they had gained weight.

One person's food, fluid and nutrition plan had been written by the speech and language therapist because of their difficulties with swallowing. The plan included the consistency of food the person needed, that their fluids needed to be thickened and they needed to be sat in a certain position. We observed staff supporting this person to eat and drink, their food and fluids were at the consistency and they were positioned as detailed in the plan. The staff were knowledgeable about the individual's dietary needs and the need to follow their plan as the person was at risk of choking.

People told us they were consulted about meals individually and at 'residents meetings'. At the previous month's 'residents meeting' people had raised they were bored with the menu. In response the provider and cook met with people and a new two weekly menu was planned and there were plans to keep this under review. People said they enjoyed the food and if they didn't like anything the cook would cook an alternative. They told us they liked the food at the home and one person said: "it's lovely", another person said; "food is very good".

We observed nine people having the main meal in the dining room. We saw that people chose where they wanted to eat their meal. Some people ate in their bedrooms and others in the lounge or dining room. There was a relaxed atmosphere and staff chatted with people. Staff supported people at a suitable pace and they ensured people had swallowed before they offered them the next mouth full. They explained to people what they were eating and offered them choices of drinks.

Two of the people we were tracking had been identified as nutritionally at risk. We saw there were records of people's food intake to make sure they had enough to eat. These records detailed whether any of the foods were fortified as detailed in the individual's plans.

Staff told us they had supervision and felt well supported by managers and the providers to fulfil their roles. The home manager showed us the induction programme in place for staff. This included an induction programme into the home and the people who lived there. In addition to this staff completed the Skills for Care Common Induction Standards, which are nationally recognised induction standards. Staff completed a three day core training programme as part of their induction and worked alongside experienced members of staff for at least four days. Staff we spoke with confirmed that their induction had prepared them to work with people living at the home. They said that they were also provided with specialist training to meet people's individual needs.

The provider sent us the training plan and staff training matrix. Staff completed core training that included the provider's compulsory and specialist training. We saw further specialist training was booked. For example, there was specialist epilepsy and dementia training booked in July 2014. The home manager and staff told us that all staff had or were enrolled to achieve National Vocational Qualification or equivalent at level 2 or higher.

Good

Is the service caring?

Our findings

We saw good interactions between staff and people. They were chatting, laughing with each other and this showed us they enjoyed each other's company. There was stable staff group at the home and staff we spoke with had a good understanding of people, their lifestyle preferences and the way they liked to be cared for. One staff member said: "Everyone is so different but they are recognised as individuals and their needs are always acknowledged".

People spoke highly of staff and the care they received. One person said: "I get on with all staff" and another person said: "I'm so happy here. I go out with staff and the owner. There is not a member of staff I don't like". Relatives we spoke with were positive about the care provided. Comments from relatives included: "Excellent care", "Amazing, I can't speak highly enough of it there", and "The staff are friendly, patient and very accommodating". A professional commented: 'It comes across that staff genuinely care about their clients and value the person as an individual in their own right, are warm in their approach, accessible and approachable to my clients.'

Overall, people's care plans were personalised and included brief life histories for people. However, we looked at the plan for one person who was living with dementia and was no longer able to communicate verbally. The plan did not include their life history and this meant that staff may not have all the information about the individual to be able to care for them in a personalised way.

Overall, people's ethnicity and cultural needs were acknowledged and the home was holding events to celebrate different cultures. We noted that the staff had not fully considered or acknowledged people's identities and how they would support people to maintain or develop important relationships with partners or significant others. Following the inspection, the home manager sent us a new policy that included the actions they would take to address this.

One person told us they had been involved in developing their care plan. They said they had discussed with staff their specific needs and had also set some objectives. People's care plans were supported by pictures and photographs to make them easier to understand.

People said that staff respected their privacy and dignity. Staff knocked on people's doors before entering. They discretely offered people personal care and made sure that their dignity was maintained. For example, one person spilt their drink on their clothing and staff quickly responded to support the person to change their clothing.

People and or their representatives had been consulted about their end of life wishes. These were recorded and plans were in place where needed. The home manager told us they were working towards implementing the Gold Standards Framework which is a set of standards for providing the best standard of care for people at the end of their life. They anticipated being accredited in August 2014.

Good

Is the service responsive?

Our findings

During the inspection all of our observations showed us that staff were responsive to people's needs. Staff responded to people's verbal and non-verbal gestures and communication which included Makaton which is a type of sign language. They were very knowledgeable about people's communication and were able to explain how people let them know if they wanted anything. For example, they told us when a person said a certain phrase they knew what this meant. This meant they were able to respond appropriately. Another person looked anxious and their facial expression changed and staff quickly identified that the person was unsettled. The staff reassured the person and asked them if they wanted to move to a different room. They supported the person to move and stayed with them.

None of the health and social care professionals we contacted had any concerns about the home. All of the professionals commented on the proactive approach of the home. One professional wrote: 'Staff have never failed to call me to make enquiries, to discuss concerns or ask advice, nor have they failed to follow through on advice agreed upon or steps advised.' Another professional said: "They are very responsive; any advice is always followed through".

We observed that throughout the inspection staff gave information to people in ways that they could understand. For example, one person was given visual and verbal choices of activities. Another person was given visual choices of drinks.

During the week there were three activities co-ordinators working each day and they supported people to do things that were important to them both in the home and the community. We saw and people told us they had lots of opportunities to go out in the community. For example, one person told us they regularly went out with staff to go "clothes shopping and have a glass of wine". During the inspection, people went out shopping, to a local park, lunch clubs and one person who was supported by one member of staff at all times went out for a long walk and a drive.

During the inspection, people were participating in activities with staff such as word quizzes and drawing. Staff worked with each individual in a personalised way. The activities workers knew what each person's preferences were and tailored what they were doing to each person. For example, one person was supported to hold tactile objects and another person had personalised word searches printed that had words in it that were important to them.

We saw each person had a scrap book of things they had been doing. These books included photographs of activities and places people had been. These books were supported by pictures and photographs so they were an easier way for people to recall what they had been doing. The photographs we saw showed that people were smiling during the activities. One person's book included information in Braille.

The home was responsive to changes in people's needs. We saw people's assessments and care plans had been reviewed on a monthly basis. Overall, apart from for one person, action had been taken to amend care plans if people's needs had changed. Staff told us they had a hand over every day and monthly staff meetings where they discussed people's needs and if anything had changed for any individuals. There were minutes and records available and staff said managers made sure they read these. They said that these systems made sure they were all kept up to date with people's needs and things around the home.

People told us they could raise concerns with any of the staff and they would sort their concerns out. Staff we spoke with also had a good understanding of how people communicated when they were upset and how to support people to make a complaint. The three relatives we spoke with told us they knew how to make a complaint. One relative said: "I have no concerns whatsoever but if I did I would speak to the manager or owners. They are all very approachable".

There was a written and pictorial complaints procedure and each person's communication plan included details as to how they would let staff know if they were unhappy or worried. The registered manager told us that they encouraged people, relatives or representatives to raise any concerns on behalf of people and they were able to address their concerns satisfactorily. There had been no complaints made to the home in the last 12 months.

Good

Is the service well-led?

Our findings

Observations and feedback from staff, relatives and professionals showed us the home had a person centred, positive and open culture. This was because there were regular opportunities for people who lived at the home to contribute to the day to day running of the home through 'residents meetings'. In addition to this surveys are sent to people's friends and their relatives. The home manager told us the feedback from the surveys was used to identify any areas for improvement.

Professionals, staff and relatives spoke highly of the home manager, registered manager, the representatives of the provider and told us they were approachable. No one we consulted or spoke with had any concerns about the home. Comments from professionals about the management of the home included: 'The proprietors of the home appear to be hands on and will spend time with their residents and participate with interests one might have' and 'In the past when I have worked with them with a service user who still lives there, the managers have always been very approachable and have always been thinking ahead in terms of staff training and gaps in their service.' One member of staff said: "The managers are like 'family' they are very supportive, there's no excuse for not telling them things they are so approachable".

We found there were arrangements in place to monitor the quality and safety of the service provided. There were monthly audits of medication, infection control, cleaning schedules, health and safety, care plans, staff training and moving and handling competencies. We saw that where any shortfalls were identified in these audits actions were taken. For example, following a change in needs of one of the people living at the home and the recruitment of new staff it was identified that specific training was required. This training was then arranged and delivered.

We spoke with the infection control lead who told us their responsibilities which included the checking of mattresses to make sure they were clean and working correctly.

The registered manager and provider explained how they calculated and monitored staffing levels. This included making sure the one to one hours that people were funded for were provided and monitoring people's needs and increasing staffing when their needs changed. All of the people, staff, relatives and professionals told us there were enough staff to meet people's needs.

The home manager showed us the systems for monitoring any accidents of incidents. This included reviewing all accidents across the home on a monthly basis and on a three monthly basis for individuals. This was so they could identify any patterns or areas of risk that needed to be planned for.

The home had received written compliments from relatives and people' representatives. The home manager and staff said these were shared at handovers and team meetings so staff received the positive feedback.

All of the staff we spoke with knew how to whistleblow and raise concerns. They were confident that any issues they raised would be addressed. The home and registered manager gave us an example of where a staff member had whistleblown and what action they had taken in response.

There was a stable staff team at the home and staff told us they knew people well and people told us they were happy with the staff. Managers and staff told us they very rarely used agency staff and that any staff shortages were covered by the staff team. Staff we spoke with very committed to providing good quality care to people living at the home and all of the told us it was a good place to work.

There were emergency plans in place for people, staff and the building maintenance. In addition to this there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment undertaken by the registered manager and provider who were at the home at least five day a week. For example, there was an electronic computer programme that flagged up when the servicing was equipment was needed.