Stoke House Care Home Ltd

Stoke House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This focused inspection took place on 3 August 2016 and was unannounced. Stoke House Care Home provides accommodation over two floors for up to 46 older people who require residential and nursing care and treatment, some of whom are living with dementia. At the time of our inspection 18 people were living at the service.
We had previously carried out an unannounced comprehensive inspection of this service on 11 and 12 May 2016. After that inspection we received concerns in relation to how people were supported with their mobility in the service. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stoke House Care Home on our website at www.cqc.org.uk.
The service did not have a registered manager at the time of our inspection. The service had been without a registered manager for approximately 21 months. A new manager had been at the service for approximately six months prior to our inspection and had made an application to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were at risk of harm due a lack of adequate risk assessment and monitoring in relation to people's moving and handling support needs. We also found that staff had not received sufficient training and guidance in order for them to support people safely with their mobility.

Immediately after our inspection and feedback the manager confirmed the action they had, and would be taking to address our concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk had not been identified or managed appropriately. Assessments had not been carried out in line with people's individual needs. People's care records did not contain sufficient guidance for staff to minimise risks to people.

Equipment was available to support people with their mobility but this was not always used safely by staff.

Stoke House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Stoke House Care Home on 3 August 2016. This inspection was to look into concerns received since our last comprehensive inspection on 11 and 12 May 2016. We inspected the service against one of the five questions we ask about services: is the service safe?

The inspection was undertaken by one inspector and a specialist advisor who was a specialist in moving and handling. During the inspection we spoke with three people who were living at the service and viewed the care records of five people. We spoke with four members of care staff, the manager, a nurse and the training co-ordinator. We observed the support staff provided to people with their mobility in communal areas of the service. We also looked at records relating to the running of the service, such as staff training records and accident and incident records.

Requires Improvement

Is the service safe?

Our findings

People told us they had no concerns about their safety when staff were supporting them to mobilise. However we found that risks to people in relation to their mobility were not effectively assessed or managed to keep people as safe as they could be. The manager told us that approximately half of the people who lived at Stoke House Care Home required a high level of support to help them mobilise around the service.

Measures which had been identified to reduce the risk of harm to people had not always been implemented. Following an incident, the use of a specific piece of equipment had been identified that would reduce the risk of harm when mobilising for a person who lived at the service. The manager told us, and records confirmed that the equipment had been ordered and delivered to Stoke House Care Home. However, we found that the person's care plan and risk assessment had not been updated to reflect that the equipment should be used when staff assisted the person with their mobility. All the members of staff we spoke with were unaware that the person required the equipment and confirmed they had not been using it. We concluded that although the equipment was available, there was a failure to ensure this was used which meant that the person was at risk of harm. Furthermore, the manager told us that they could not identify the wheelchair or the pressure relieving cushion that the person was using at the time of the incident. This was because the equipment not the persons own, but from a pool of equipment available at the service. No assessment had been carried out on the suitability of the wheelchair or the pressure relieving cushion for this person.

We observed that equipment was available to support people with their mobility but was not being used safely to assist people to move around the service. Stoke House Care Home's policy in relation to manual handling stated that, "The manager will arrange staff manual handling training that is carried out by suitably qualified trainers who will ensure that current good-practice techniques are taught." We spoke with the training co-ordinator who told us that new staff completed a moving and handling practical session on the first day of their employment at Stoke House Care Home. They told us this involved new staff having to demonstrate how to support people with moving and handling including how to use a hoist and position a sling and that new staff completed a checklist for various moving and handling tasks. However, we identified that the checklist did not cover specific subjects such as identifying different types of slings, ensuring that sling sizes and types are suitable to people's individual needs or how people should be positioned prior to being assisted to transfer. In addition, these checklists had not always been fully completed. We spoke to two members of staff about an incident which had occurred when they were supporting a person with their mobility. Our discussions with staff and observations demonstrated there was a lack of awareness of current good practice and insufficient guidance available for staff in relation to moving and handling which left people at risk.

Appropriate risk assessments had not always been carried out in line with the manufacturer's guidance before equipment was used to assist people with their mobility. We observed staff support four people with the same piece of equipment. The manufacturer's instructions for the sling used during our observations stated that, "A risk assessment must be carried out to ensure that the correct size and style of sling has been met before use." We did not see any evidence that appropriate risk assessments had been carried out which

took into consideration people's individual needs such as the person's weight and height, their medical history or any assistance they required with positioning. This meant that equipment was being used in a way that was not in accordance with the manufacturer's instructions which could place people at risk of harm.

Not all of the staff we spoke with told us that they read people's care plans. We saw that staff did not always use the equipment the person required as specified in their care plan. For example, two of the four people we observed being supported with their mobility were not supported using the correct sized sling as identified in their care plan. In addition, care plans lacked detail about the type of equipment required for specific moving and handling tasks. We saw that four people were transferred using a piece of equipment which was not suitable for the type of transfer they were being supported with. This meant that staff were not provided with sufficient information to enable them to support people to mobilise safely within the service.

We concluded that risks to people's safety were not being adequately assessed which placed them at risk of receiving unsafe care and treatment. Staff had not received adequate training to ensure they had the skills and competence to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Following our inspection, the manager told us of the immediate action they had, and would be taking in response to our feedback. This included, arranging further training for the training coordinator and staff, carrying out risk assessments in relation to the equipment people required and updating care plans.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not being adequately assessed which placed them at risk of receiving unsafe care and treatment. Staff had not received adequate training to ensure they had the skills and competence to keep people safe. Regulation 12 (2) (a) (b) (c)

The enforcement action we took:

Warning notice