The Hospital of God at Greatham

Stichell House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection took place on 25 and 29 September 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Stichell House provides care and accommodation for up to 35 older people. On the day of our inspection there were 34 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Stichell House was inspected by CQC on 14 July 2016 and rated Requires improvement overall and in the Responsive and Well-led domains. At the inspection in July 2016, we identified the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (Person-centred care) and Regulation 17 (Good governance). We carried out a focussed inspection on 9 January 2017 to look at the Responsive and Well-led domains. We found improvements had been made in these areas and re-rated the service as Good.

At this inspection we found accidents and incidents were appropriately recorded and investigated.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs.

Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Stichell House. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint but did not have any complaints about the service.

The provider had an effective quality assurance process in place. Staff said they felt supported by the manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff with their dietary needs.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had good links with the local community.

Stichell House

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 29 September 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with eight people who used the service and two family members. We also spoke with the registered manager, care services manager, director and four members of staff.

We looked at the care records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We carried out observations of staff and their interactions with people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to talk with us.

Good

Is the service safe?

Our findings

People who used the service felt safe at Stichell House. They told us, "I feel very safe here and my possessions are safe", "I accepted this home because I knew it was safe and I would be well cared for", "I had three falls at home but I haven't had any here."

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff, and on an ongoing basis as necessary.

We discussed staffing levels with the registered manager and looked at staff rotas. A dependency tool was used to calculate staffing levels and we observed there were sufficient numbers of staff on duty, and call bells were answered in a timely manner. Staff, people who used the service and visitors did not raise any concerns about staffing levels.

The home was clean, spacious and suitable for the people who used the service. Communal bathrooms and toilets were large, clean and suitable for the people who used the service. There were no unpleasant odours in any part of the home. Appropriate personal protective equipment (PPE) and hand hygiene dispensers were in place and available. This meant people were protected from the risk of acquired infections.

Accidents and incidents had been recorded and analysed to identify any trends. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. Risk assessments included moving and handling, risk of falls, nutrition, and the use of bed rails. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014).

Equipment was in place to meet people's needs and where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed. For example, a fire risk assessment was in place, fire alarm tests took place regularly, firefighting equipment, the fire alarm and emergency lighting were regularly checked and serviced. Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy, which defined who is an adult at risk, what is abuse, what to do if abuse was suspected, staff responsibilities and a safeguarding procedure flow chart. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The registered manager understood their responsibility with regard to safeguarding and staff received training in the protection of vulnerable adults. We found the provider understood safeguarding procedures and had followed them.

We looked at the management of medicines and saw medicines were securely stored. Daily temperature checks were carried out to ensure medicines were stored at a safe temperature.

Medicine administration records (MAR) we viewed were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. MARs included an up to date photograph of the person, details of the person's GP, whether the person had any allergies, and their preferred method of administration.

A medication risk assessment was in place for the home, staff were appropriately trained and medicines audits were carried out regularly. This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People told us, "Staff know what they are doing when they give me a bath, I have no worries", "I have to use a wheelchair and there are always two members of staff helping me, they seem very confident" and "I need to use a hoist and there are always two carers."

New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. Staff mandatory training included moving and handling, infection control, safeguarding adults, food hygiene, dementia awareness, fire awareness, health and safety, dealing with behaviours that challenge, equality and diversity, first aid, medication awareness, and mental capacity. Mandatory training is training that the provider deems necessary to support people safely. The majority of the training was up to date and where gaps had been identified, training was planned.

Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

People were supported with their dietary needs. People who were at risk of malnutrition or choking had been referred to the speech and language therapist (SALT) and their guidance was included in the person's support plan. Nutritional assessments were carried out, up to date risk assessments were in place and people were weighed regularly. Kitchen staff were aware of people's individual dietary needs and their food preferences had been recorded.

We observed the lunch time experience. It was a pleasant atmosphere with people chatting amongst themselves. The dining room was spacious and large enough to accommodate wheelchairs and walking aids. There were sufficient staff to assist with lunch and we saw them chatting to people as they served the food. Staff addressed people by name and had a very calming and warm manner towards them. The food looked appetising and people were given a choice of what they wanted to eat and drink. The chef came into the dining area asking people if they had enjoyed their lunch and had a friendly chat with them. We spoke to people during lunch who all told us they had enjoyed the meal.

People had support plans for their communication needs. These included information on how the person communicated, their personal preferences and what interventions were required from staff to support them. For example, one person was at risk due to word finding difficulties and had poor eyesight. Staff were directed to speak with the person in a clear manner, reiterate information as required and ensure there was sufficient lighting in the person's room.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the registered manager had a good understanding of their legal responsibilities with regard to the MCA and DoLS, and staff had received training in the MCA. Applications for DoLS had been submitted to the supervisory body, mental capacity assessments had been completed for people and best interest decisions made for their care and treatment, where applicable.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service had been involved in the decision making process.

The home was appropriately designed for the people who lived there. Some of the people who used the service had a dementia type illness and the service had incorporated some design aspects that were dementia friendly. For example, corridors were wide and clear from obstruction, handrails contrasted with walls and carpets, and people's bedroom doors and communal facilities were clearly signed and identifiable. The registered manager told us they planned to redecorate each floor to make them different so it would aid people's orientation around the home.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external specialists including GP, SALT and community nursing teams.

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Stichell House. They told us, "Staff are very friendly, kind and caring", "I am back to myself again, I don't feel lonely anymore" and "I am looked after very well. The staff are lovely and cheerful."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity.

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records described how people wanted to be treated and what staff should do to respect their privacy and dignity. For example, "I need you to be kind to me as I can get really upset sometimes", "Make sure I am always wearing my glasses so I can read and watch television", "[Name] is a very proud lady who takes pride in her appearance" and "Staff to ensure [name] visits the hairdresser at Stichell House on a weekly basis as this is something she has always done." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Care records described how people were supported to be independent. For example, "Encourage [name] to participate in personal care by washing her face, hands and upper body twice daily", "Staff to present toothbrush and [name] will attempt to clean herself", "To maintain [name]'s independence whilst mobilising, prompt the use of the walking stick and close monitoring by staff" and "[Name] is able to wash the top half of her body independently."

Small kitchens were available in the home for people and visitors to use. Staff told us this helped to promote people's independence. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Bedrooms were individualised, some with people's own furniture and personal possessions. All the people we spoke with told us they could have visitors whenever they wished. The family members we spoke with told us they could visit at any time and were always made welcome.

Advocacy information was available on the home's notice board and included contact details for a local advocacy service. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The registered manager told us none of the people using the service at the time of the inspection had independent advocates.

The service had considered the needs of people with dementia. The provider's care services manager had carried out dementia awareness training with staff and a visiting health care professional was introducing dementia related initiatives into the home. These included the purchase of an electronic tablet that was going to be used to record videos of family members that could be played back to their relatives in the

home. The registered manager told us they had received a positive response from family members regarding this.

People's preferences for their end of life care had been recorded, where appropriate. This included information on the person's preferences, religious practices and where they wished to receive end of life care. Staff had received relevant training and the home had been awarded the 'Gold standards framework' for the quality of the care provided for people in the final years of life.

Good

Is the service responsive?

Our findings

People's needs were assessed before and after they started using the service in order to develop care plans. We found care records were regularly reviewed and evaluated.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. For example, people were able to make choices about their night time care such as what time they went to bed, whether they preferred sheets or a duvet on their bed, and what time they preferred to rise in the morning. One person told us, "I can go to bed when I want; if I want a lie in they just leave me to it."

Each person's care record included a 'This is me' document, which included information such as what was important to the person and how best to support them. This was used to assist with the development of the person's support plans and we saw it had been written in consultation with the person who used the service and their family members.

People had individual support plans that included personal hygiene, elimination/continence, nutrition, mobility, psychological and emotional health, communication, behaviour, cognition, skin integrity, breathing, sleep, medication, environment, sensory, and foot care. Each plan identified the person's need or risk in that area, the aims and objectives of the plan, what care and support interventions were required, and an evaluation record.

For example, one person had been identified as being at risk of skin damage. Staff were directed to re-position the person every three hours, support the person with their personal care and apply prescribed creams as required. If any concerns were identified, staff were to report to the duty manager as soon as possible. We saw a body map had been completed for the person, an up to date risk assessment was in place and appropriate health care professionals had been involved in reviewing the person's care.

We found the provider protected people from social isolation. Each person had a 'Social profile' that recorded important information from their past, such as religion, work history, school, community involvement, activities they enjoyed doing, television and newspaper preferences, and significant people in their lives. These were completed by the activities coordinator, with the assistance of the person, family and friends, and used to plan activities. For example, one person enjoyed craft and musical activities, and used to bake a lot when they lived in their own home. They were able to access these activities at the home.

Upcoming events were advertised on the home's activities board. These included an auction, a 'cake off', a charity coffee morning, Holy Communion and group activities in the dining room. We asked people if there was much to do at the home. One person told us that they had a garden party on the lawn with folk singers which was very enjoyable. Other people told us, "A timetable of activities is delivered to my room every Monday", "I can go out when I want if the carers have the time", "I join in with all the activities, I have just started knitting", "I take the chocolate trolley around with [activities co-ordinator]", "Two lovely carers from the home take me to church and bring me back" and "I try and go out on the day trips that are arranged."

The provider's concerns and complaints procedure was visible on the home's notice board. This described the procedure for making a complaint, how long it would take to receive a resolution to a complaint, and relevant contact information. There had not been any recent complaints at the service. The registered manager told us they believed this was due to their "open door policy" and any concerns were dealt with immediately before they became formal complaints. People and family members we spoke with confirmed this. They told us, "I would certainly go to [registered manager] if I had any concerns, she is very helpful" and "Her [registered manager]'s door is always open."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us about plans for the redecoration of the home and to expand the sweet shop to make a gift shop. This would help promote independence as people would be able to carry out some of their own shopping instead of relying on staff going to the shops for them.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had a positive culture that was person centred, open and inclusive. People who used the service and family members told us, "[Registered manager] is very good and approachable, she is a consummate professional" and "[Registered manager] has a lovely friendly smile. She has a lovely nature and is so kind."

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. Staff were regularly consulted and kept up to date with information about the home and the provider via staff meetings and newsletters.

The service had good links with the local community. These included links with the local primary school, visits to the local pub and activities, including a pantomime at the village community centre.

We looked at what the provider did to check the quality of the service and to seek people's views about it. The provider had a 'Registered services governance, audit and improvement policy' in place, which described the framework for their system of governance, audit and improvement.

The registered manager and senior staff carried out audits of the service, which included health and safety, medication, premises, health and safety, and care records. We viewed a sample of these audits and found they were up to date and included action plans for any identified issues. For example, a number of issues had been identified during medication audits earlier in the year. These had been actioned immediately and the number of identified issues had reduced significantly in recent months. We saw copies of memos sent from the registered manager to staff including guidance and reminders regarding medicines recording and managing stock. A recent visit from a medicines specialist from the local clinical commissioning group (CCG) praised the service on the improvements made to their management of medicines.

As part of the quality assurance process, the provider's care service manager scrutinised the registered manager's audits and carried out their own audits of the service, which included preparing a bi-monthly report for the director.

Residents' meetings took place regularly and an annual survey was carried out that asked for feedback on

people's quality of life, staff, activities, food, environment, complaints and the care provided.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.