The Hospital of God at Greatham

Stichell House

Inspection report

The Hospital of God at Greatham
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Ratings

Overall rating for this service	Good

Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This focused inspection took place on 9 January 2017 and was unannounced.

We carried out an unannounced comprehensive inspection of this service on 14 July 2016. Breaches of legal requirements were found. Specifically the provider had breached Regulation 9 – Person Centred Care and Regulation 17 - Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Clear care plans with detailed guidance were not always in place. Care plans did not always include ways in which people could maintain their independence. The lack of detail in care plans meant they were not always up to date with changes to people's needs and preferences. A complete and accurate record of each person's care and treatment was not maintained. Systems to assess, monitor and improve the quality of care records were not always effective in identifying where quality was being compromised.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

Stichell House is a care home without nursing and can accommodate up to 35 people. At the time of the inspection there were 35 people using the service. All bedrooms are single and have ensuite toilet and wash basin facilities. Accommodation is provided over three floors, all of which have tea bar facilities. There is a communal dining area and lounge facilities as well as attractive, landscaped grounds. Stichell House is situated on the edge of Greatham, a quiet residential village, in the Hospital of God estate.

A registered manager was registered with the Care Quality Commission at the time of the inspection. 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 improvements had been made. The quality and detail in care plans had improved. Information about people's history and preferences were recorded in a person centred way.

Detailed strategies were in place for staff to follow to ensure people received appropriate care. Records were reviewed on a monthly basis or in response to a person's changing need.

A new quality assurance system for the audit of care records had been introduced. Since the last inspection every person's records had been audited at least once, actions had been identified to improve the quality

and consistency of information and checks had been made to ensure actions had been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service responsive?

Good

The service was responsive.

We found that action had been taken to improve care records. Care plans were detailed and individual to the person. They contained information on the person's preferences as well as how care should be provided to ensure their wellbeing.

Is the service well-led?

Good

The service was well-led.

We found that action had been taken to improve quality assurance. A new quality assurance system for the audit of care plans had been introduced which was effective in ensuring improvement in the quality and completeness of care records.

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.

We undertook an unannounced focused inspection of Stichell House on 9 January 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 14 July 2016 had been made. We inspected the service against two of the five questions we ask about services: Is the service responsive? And Is the service well-led? This is because at the last inspection the service was not meeting legal requirement in relation to those questions.

The inspection was undertaken by one adult social care inspector.

Before our inspection we reviewed information we held about the service and the provider such as the action plan the provider submitted setting out how they would become compliant with the breach identified at the previous inspection.

During our inspection we looked at care records for three people using the service. We spoke with the manager and two duty managers.

Good

Is the service responsive?

Our findings

During our last inspection in July 2016 we found clear care plans with detailed guidance were not always in place. Care plans did not always include ways in which people could maintain their independence. The lack of detail in care plans meant they were not always up to date with changes to people's needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care.

During this inspection we found improvements had been made to ensure regulations were met, and people's care records were complete, up to date and personalised.

A duty manager said, "We have had some more training and it was a light bulb moment. There's lots more detail in care plans now, we see something new each time we look at them and they change all the time as people's needs change."

Care records included person centred documents such as one page profiles, This is Me, and social profiles which provided staff with detail on the person's life story, what was important them, significant events in their lives, and how best to support them. This meant the information could be used to get to know the person better and form positive and trusting relationships. If people had specific preferences these were recorded, such as, 'likes to be up and ready for 9.30am,' and 'likes to use nice smelling soaps and body wash.' There was also detail in relation to where people could be supported to maintain their independence as they did not need staff support with that specific aspect of their care.

Care plans described the person's need, the aim or objective and the care interventions which were needed to support the person. Care plans were in place for a range of needs including personal hygiene, continence care, mobility, and nutrition as well as communication, emotional health and behaviour.

The number of staff required to support people for specific needs was noted which meant people would not be over supported. This also maintained people's dignity. If two staff were needed for support with transfers but the person needed one staff member to support with personal care this was recorded.

The level of detail was such that staff had an awareness of any specific triggers which could cause the person upset or distress and there were specific strategies to follow if people were anxious or disoriented, such as needing to spend time with a person after lunch.

Mobility and falls care plans were in place and included some information on the support people needed with mobilising. We found a separate document titled safer handling care plan/risk assessment for manual handling which detailed the number of staff and specific equipment needed to support people with transfers. This document also detailed specifics on how people should be supported when walking. For example, staff to place 'one arm on [person's] waist and the other holding on gently to [person's] left elbow.' Bed rail assessments were in place but were kept in a different section of the care file. We spoke with the registered manager about cross referencing all the information on people's mobility needs so care staff

knew to read every document to gain a full picture of people's needs.

Good

Is the service well-led?

Our findings

During our last inspection in July 2016 we found a complete and accurate record of each person's care and treatment was not maintained. Systems to assess, monitor and improve the quality of care records were not always effective in identifying where quality was being compromised. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

During this inspection we found improvements had been made to ensure regulations were met, and systems and processes had been established and operated effectively to ensure compliance.

The registered manager said, "I audit five files a week, which was implemented at the beginning of August 2016." They explained, "The duty managers do a monthly update (review) of all care plans. They also action any of my findings from the audit. Once I've done my audit a copy goes to the duty manager, they complete the actions and sign it off." They also explained, "The care services manager completes two (care plan) audits a month and audits a sample of my audits to make sure actions have been done. The director does bi-monthly audits (of care plans) and the trustees do a bi-monthly visit which includes a review of two care plans."

We saw all care files had been audited by the registered manager since the last inspection. Many had been audited twice by the registered manager and the audits had been effective in improving the quality and timeliness of information within care plans.

Identified actions included requests to update information, clarify inconsistencies, complete reviews and to add more specific detail to areas such as mobility plans. The duty managers had initialled and ticked to identify when the work had been completed and the registered manager was also ensuring the actions had been completed.

One duty manager said, "Lots has changed, we have new audits now." During the inspection we saw one duty manager updating a file and responding to audits completed by the director. They had recorded on the audit the action they had taken in response to the comments made.

The audits completed by the care services manager were detailed and posed specific questions as prompts for the level of detail required. As well as noting when information needed to be updated or if it was confusing or contradictory. The director's audits also followed this process and included a section titled 'general comments.' These comments included things such as, 'care plan easy to navigate,' and 'pleased to see care plan had been updated promptly following recent hospital stay.'

The audit process was effective in ensuring improvements which meant care records were accurate and complete.