Stone House Care Home Ltd

# Stone House Residential Home

## Inspection report

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28 December 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

We carried out an inspection on the 20 and 28 December 2017. The first day was unannounced.

This was the first inspection of the service since it was registered in June 2016.
Stone House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Stone House accommodates up to 35 people in one adapted building over two floors. There were 26 people accommodated at Stone House at the time of this inspection.

The service had a registered manager. 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. The registered manager was not present when we visited the service although arrangements had been made for a temporary manager to run the service to ensure continuity.

We have made a recommendation about care records. Records outlining the daily fluid intake of some people were maintained yet did not indicate daily targets for people to be achieved. While there was no evidence that this had a negative impact on people.

People told us that the felt safe living at Stone House and that they always received their medication when required. People told us that there was always staff around to assist them. Medication was well managed and promoted the health of people who used the service.

People lived in an environment that was clean and hygienic. The premises were well maintained with equipment being checked to ensure it was safe to use. The environment was designed to enable people to move around independently and remain safe.

People were further protected by the robust recruitment of new staff. The registered provider demonstrated that staff received up to date training on topics which related to the needs of people.

Staff were sufficient in number to meet the needs of people who used the service. Where shortfalls in staffing were identified, efforts were made to ensure that continuity could be maintained by using exiting staff to cover shifts.

Accidents and incidents were recorded and analysed to prevent future re-occurrence or identify future trends.

Staff received training and supervision which was suitable for their role. A structured induction process was in place enabling new staff to become familiar with their role and the needs of people who used the service.

The registered provider took the requirements of the Mental Capacity Act into consideration and ensured that the best interests of people were served.

The nutritional needs of people were met with people's preferences respected. Food was well prepared in clean and hygienic facilities.

People felt that staff cared about them. Observations of care practice noted that people were treated in a respectful and dignified manner. Staff gave practical examples of how the privacy of people could be maintained.

Advocacy services were in place for individuals and consideration was given to ensuring that communication between staff and people whose first language was not English enabling their needs and preferences to be known.

Staff were aware of the likes and dislikes of people and individuals were able to personalise their rooms to their own tastes.

People's care plans were checked on a regular basis to ensure they were accurate and up to date. Care plans included an acknowledgement of the health needs of people but also placed emphasis on their social history and interests. We saw that care practice matched the information included within care plans.

An activity programme was in place and ensured that people had the opportunity to join in if they wished.

People were provided with the opportunity to remain independent in pursuing their own interests both within and outside of the service and in maintaining their own personal care and management of medication.

People did not have any complaints but were confident that the registered manager would listen to them and act upon them. No complaints had been received by the service or CQC. There was evidence that some informal concerns were dealt with informally before formal complaints were made. This meant that a proactive approach was used in complaints management.

People told us that they felt that the service was well run. Staff told us that the management team were approachable. Arrangements had been put into place to ensure that arrangements had been made to ensure continuity while the registered manager was absent.

A number of audits were in place to assess the quality of care provided and the views of all concerns, such as people who used the service, families, staff and health professionals were gained to inform the quality of the service provided.

The registered provider understood the need to inform CQC of those incidents which adversely affected the wellbeing of people who lived at Stone House.

Community links were established between the service and local agencies.

## 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

Fluid balance records were not always completed which meant that the hydration people received could not always be accounted for. We have raised a recommendation in this report.

Staff had a good understanding of the types of abuse and how to report any concerns.

The premises were clean, hygienic and well maintained.

Sufficient staff were employed to safely meet the needs of people who used the service.

### Is the service effective?

Good

The service was effective.

Staff received the training and supervision required to perform their role.

The registered provider had followed the requirements of the Mental Capacity Act.

Consent to provide support was gained from the people who used the service.

The nutritional needs of people were met.

### Is the service caring?

Good

The service was caring.

People were treated in a kind and respectful manner.

The limitations people had in communicating were taken into account by the staff team.

Information and explanations were always provided to people.

### Is the service responsive?

Good

The service was responsive.

Care plans were personalised and covered the medical and social needs of people.

Activities had been improved following a Healthwatch visit with links to local community groups having been fostered.

A complaints procedure was in place. No complaints had been received about the service.
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## Is the service well-led?

Good

The service was well led.
Arrangements had been made to ensure continuity of care during a period of temporary absence of the registered manager.

The quality of the service was checked and included the views of people who used the service, their families, staff and health professionals.

The registered provider always notified the Care Quality Commission of adverse incidents affecting the people who lived at Stone House.

# Stone House Residential 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.

This inspection took place on the 20th and 28th December 2017 and was unannounced on the first day with the second day being announced.

The inspection consisted of one Adult Social Care Inspector.

As part of our inspection, we ask registered providers to complete 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. The PIR was returned to us when we asked.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at care plans for seven people and other records such as three staff recruitment files, training records, policies and procedures, medication systems and various audits relating to the quality of the service. We also observed care practice within the service.

We spoke to five people who used the service. We also spoke to the acting manager and three members of staff. We also observed care practice and general interactions between the people who used the service and the staff team.

We looked at information from the last visit made by the Local Authority Commissioning Team. They had not recently visited the service. We contacted the Cheshire West Healthwatch team. Healthwatch is an

independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. The team last visited in August 2016 and had identified some minor points for improvement.

Good

# Is the service safe?

## Our findings

People told us that they felt safe living at Stone House. They said "Oh yes, absolutely I feel safe", "Yes I do feel safe living here" and "No I have no worries or concerns about living here". People told us that there were always enough staff around for them to summon help if required. People told us that they received medication when they needed it and that it was never missed.

Our records indicated that there had been no safeguarding incidents within the service since it was registered under new providers. Information was in place on how any concerns or abusive practice could be reported to other agencies such as the Local Authority. Training records outlined that staff had received recent safeguarding training. Staff demonstrated a good awareness of the types of potential abuse that could occur. They were clear about the process within the service about escalating such concerns and were confident that the management team would report any allegations appropriately. A whistleblowing procedure was available which provided staff with the information to report poor care practice and other concerns to external agencies such as the Care Quality Commission. Staff were aware of the whistleblowing procedure and which external agencies to whom they could raise concerns.

One person managed their own medication. This had been risk assessed to ensure that this could be done safely and this enabled the person to be independent. Medication was securely stored in a treatment room which in turn was locked when not in use. Some people had been prescribed controlled medications. These are medicines that are controlled under the Misuse of Drugs legislation. These were securely and separately locked. A register was maintained to ensure that all controlled medications could be accounted for. We checked medicines for two people and found that the stock tallied with the register. An additional stock check record was completed throughout the day to confirm accountability for these controlled medicines. All other medication was presented in a blister pack and these demonstrated that people had received medications when needed. Some medicines required to be stored at cooler temperatures to ensure their effectiveness. A separate medication refrigerator was available and the temperature of this was checked through the day.

Medication administration records (MARS) were signed appropriately and in case where medicines had been refused for example, a code had been recorded to indicate the reasons for this. All MARS contained the numbers of tablets that had been received and by whom. Audits were carried out to ensure the effectiveness and safety of the management of medication. Staff responsible for administering medication had been trained to do so and had their competency periodically checked. Disposal records were maintained to further ensure accountability for all medications managed by the staff team.

We observed medicines being administered. This was done in a discreet manner with people being informed of what medication they were being offered. A drink was offered to people to help them to swallow any medication.

A staff rota was available. This provided evidence that senior care staff were on duty as well as other care staff. Ancillary staff such as kitchen staff and domestic staff were employed by the provider to ensure that

care staff could concentrate on their role. There was evidence that staffing levels had been reviewed to ensure that the needs of people were being met. Where shortfalls of staff occurred, steps were taken by the provider to ensure that staff could be identified to work and ensure people's needs could be met. Staff told us that staffing levels were well maintained although at times the dependency of people fluctuated and that additional staff would be of benefit.

Recruitment files indicated that the registered provider sought to ensure that people who used the service were only supported by people who were suitable to perform the role. Files indicated that new staff received a Disclosure and Barring check (known as a DBS). A DBS is a check made to see if people had been convicted of offences which would affect their suitability to work with vulnerable people. References were in place as well as information confirming the identity of the individual. Interview notes were in place enabling the registered provider to make a judgement on the skills, values and experience of potential candidates. All recruitment files were audited to ensure that all appropriate documentation had been received. One member of staff we spoke with had recently been recruited and considered that the recruitment process had been thorough.

The premises were clean and hygienic with no offensive odours. Domestic staff attended to their tasks throughout our visit. Domestic staff had access to sufficient personal protective equipment (PPE) to minimise the spread of infection. This equipment was also available to care staff to use while supporting people with personal care. There were sufficient handwashing facilities available in the building for staff to use such as paper towels, soap and hand sanitisers. Guidance for effective handwashing was also available for staff in key areas.

The premises were well maintained. The registered provider employed a maintenance member of staff. Maintenance records were available which outlined repairs that needed to be done and the date when they were actioned. All areas of the building were in a good state of repair and decoration. Records were available outlining the servicing of key equipment used within the service. Hoists had been serviced within the required six month timeframe and portable electrical appliances had been checked annually as required. Fire detection and firefighting equipment had also been checked and serviced.

Risk assessments were available outlining the action staff should take in the event of an emergency evacuation. The specific needs of each person during such an event had been assessed with the levels of staff support required to effect a safe evacuation and to provide reassurance to them. A place of safety had been identified in a local church for people if the building needed to be evacuated. These personal emergency plans (known as PEEPS) had been recently reviewed. Nominal role calls were also available at key points of the building providing a summary of assistance required for staff use.

Further assessments relating to the risks faced by people in their daily lives were included within care plans. These made reference to risks in manual handling, frequencies of falls and risks with nutrition such as choking risks. No person had pressure ulcers at the time of our visit yet there was information for staff on the prevention of these and how people should be regularly reviewed to ensure that people did not develop these.

We recommend that the service consider current guidance on the completion of care records. Records had been reviewed regularly. Confidential records were securely stored away. Records were maintained outlining the fluids that people had taken during. These provided an account of fluid balance but while they were completed, there was no target set as to how much fluid a person should have in a day. As a result, there was no indication as to whether people had received sufficient hydration. Other records did indicate that staff were aware of the risks people faced of dehydration and potential infections which would in turn

affect people's health. The inclusion of totals on records would have given health professionals a better indication of the hydration levels of people. It was considered that this was a recording issue as opposed to a poor outcome for people.

Good

# Is the service effective?

## Our findings

People told us, "The food is very good" and "If I don't like something they will always make sure I can have something else". People told us that they thought that staff were good at their jobs and knew their needs, likes and dislikes. Relatives were very complimentary of the way that the staff team had assisted in ensuring that their relatives had progressed well since living at Stone House.

Staff confirmed that they received supervision. A supervision matrix was in place outlining the frequency of supervision to be held through the year and these were marked as actioned within the matrix. Records suggested that staff had an active involvement in the preparation of supervision sessions and influenced the content of them. Staff who had been employed at the service for some time confirmed that they had received an annual appraisal of their performance.

Staff told us that they received training. This training had included health and safety topics as well as topics related to the needs of people. Training linked to mandatory health and safety topics included fire awareness, infection control, first aid and food hygiene. Other training had been provided in respect of safeguarding vulnerable adults, dignity, equality and diversity and person centred care. Training was confirmed through training certificates.

Communication within the staff team was effective. This involved verbal communication between staff members about issues affecting people who used the service and other matters to ensure the smooth running of the service. This was reinforced by written communication in the form of diaries and other records. Significant and relevant information was available for staff throughout the building and in the main office.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Staff had received training in the Mental Capacity Act and were able to give an overview of the aims of the legislation in enabling people to make choices for themselves. Care plans included an assessment of people's capacity and outlined a process for ensuring that any action taken was in the best interests of people. Four people had had their capacity assessed and had been the subject of applications to the local authority for deprivation of liberty safeguards. These had been granted. Staff were aware of the people these applied to and the actions needed to ensure that these people's best interests were upheld.

Consent to the support provided was gained in a number of ways. We observed staff asking people for consent verbally and offering explanations before providing support. Support was only provided once the person had agreed to it. In other cases, people had signed care plans to confirm their agreement with their content.

A structured induction process was in place. This involved an orientation of the building as well as progression towards completing the care certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if people are 'new to care' and should form part of a robust induction programme. One member of staff outlined the induction process. This had involved orientation to the building as well as care practices undertaken by the service. A period of two weeks shadowing exiting members of staff had taken place until the person was competent to work unsupervised. The staff member considered that the induction process had enabled them to settle into their role and that staff had been very supportive during that time.

Records indicated that the nutritional needs of people were taken into account. Records outlined that people were weighed on a weekly basis and records sampled outlined that people's weights had remained stable over a period of time.

Discussions with people who used the service noted that some people had dietary preferences as a result of lifestyle or cultural considerations. Vegetarian diets were available for people who preferred not to eat meat and this was respected. We saw examples of people who ate certain foods as part of their culture and again this was recorded and taken into account.

Lunchtime was a relaxed affair and an opportunity for people to socialise. During lunch, we observed that the dining facilities available were of sufficient size to accommodate all people who lived at Stone House. The dining room had a cold water dispenser as well as a glass refrigerated cabinet displaying cakes and cold drinks that people could take if they wished. Most people were able to eat independently. Where assistance was needed, staff assisted people, with their consent, to cut up their meals or prompted them to ensure that each part of their meal was manageable.

Prior to lunch being served, staff were attentive to people and ensured that they had a drink and were comfortable. People were given information on the choices available as well as what the meal consisted of. A menu was on display and staff maintained records of the meals that were provided to each individual.

A chef and kitchen assistant were employed. The kitchen was a well-equipped facility with all the equipment needed to prepare and provide meals. There a plentiful supply of food available including fresh vegetables and fruit. Foods requiring refrigeration and freezing where appropriate. The kitchen was clean and schedules of cleaning were available to demonstrate routines to ensure good hygiene. Information was available indicating the dietary needs of people as well as how meals should be present to each. The service had been inspected by the local authority food hygiene team in November 2017 and had been awarded a maximum of five stars.

Records evidenced the ongoing involvement of health professionals in people's care to ensure that they remained healthy. People either had general checks on their health from health professionals or were attended to in response to conditions that they had acquired. Records outlined that a number of health professionals had been involved with people and these included doctors, district nurses, opticians, chiropodists and dieticians. Where people had been involved in any accidents, evidence was available outlining prompt and appropriate action by staff to seek medical help for people.

The premises had a passenger lift. We observed that people were able to mobilise through all parts of the building and were able to access outside garden areas.  People had access to an outside courtyard for use in finer weather. People were encouraged to take a portable call alarm with them to summon assistance from outside if needed.

Good

# Is the service caring?

## Our findings

People told us "Staff are very kind" and "They are very caring". Other comments from relatives included "My relative doing well and I am really impressed with the home", "My relatives progress has all been down to the staff, my relative is happy and they are doing a fantastic job". A visiting health professional said "They really look after the people who live here".

Staff interactions with people were positive throughout our visit with people being spoken to in a friendly and respectful manner. There were many examples seen during our visit of staff knocking on doors before entering and dealing with people in a reassuring and kind manner. Staff gave us practical examples of how they would ensure that people's privacy was maintained while being supported with personal care.

People were involved in their day to day care through conversations that staff had with them. Additional steps were taken by the registered manager to meet with each person individually. We saw records of these meetings with individuals in which they had the chance to outline what they wanted from their lives at Stone House and to raise any issues they had. This was seen as a proactive approach which minimised any concerns developing into a formal complaint.

The communication needs of people were taken into account. Care plans outlined the communication needs of people and whether extra consideration was needed to ensure that staff could communicate effectively with people who had sensory limitations. Where people did not use English as their first language, a booklet had been devised with words and gestures linked to that person's native language. This enabled the person to be understood and to enable staff to communicate effectively with them.

One person received support from advocates. This was because the person lacked capacity to make their own decisions and did not have any people involved on a day to day basis to assist independently of the service. We were told that the advocate visited on a regular basis to assist with this person's welfare and interests.

Bedrooms were personalised to the tastes of individuals. Items such as ornaments, photographs and furniture were present in rooms enabling people to personalise their own accommodation. The independence of people was maintained. Care plans outlined those areas of daily life which people could still manage safely and independently. This included managing medication, mobilising and eating.

People were able to maintain relationships with people outside of the service. One person regularly visited a relative within the local area and arrangements had been made by the staff to ensure that this was still possible. The person was not present for lunch yet staff held discussions to ensure that lunch would be ready for them on their return so that they would not miss out on having a meal.

Information was provided to people either through written information or verbally. There was evidence throughout our visit that people were given the information they needed and that explanations were provided as to how people were to be supported. Consent for people's support was always given before staff

would intervene.

Good

# Is the service responsive?

## Our findings

People told us "I am very happy here and have no complaints" and "I have no complaints at all but I would know who to speak to if I did". People were able to give an account of the activities on offer and told us that there was always something to do. Other preferred not to participate but knew that they could join in if they wished.

The last Healthwatch visit to the service in 2016 had identified that activities were not varied and recommended that some work be done to expand the range of activities available. Our visit found that activities were in place and that these met the needs of people. These included local community groups and entertainers visiting the service. A timetable of activities through the week was on display on a large board in a corridor area. The board contained pictures and symbols of what activities were available during the week as well as extra activities. These extra activities included events leading up to the Christmas period. Weekly activities included group sessions such as light exercise and one to one sessions. During our visit, nail manicures were being offered as well as a Christmas event later in the day. Records were maintained as to who had participated. These outlined that people had been given the choice to join in or otherwise and the degree to which people had enjoyed each session.

All people living at Stone House had a care plan. Care plans were accompanied by assessment information. Assessments had been completed by the service prior to admission and included all the relevant needs of individuals. These needs included medical and social histories and highlighted were support would be needed in their daily lives. Assessment information was also available from other agencies such as local authorities again outlining key areas of need.

Care plans were up to date and were accompanied by daily records. Daily records provided an account of the progress of people and significant events that they had experienced from day to day. Daily records served to supplement key areas of care plans. Care plans were person centred. This meant that the views of people had been included within care plans as much as possible. Where people lacked capacity to provide their views, a process was documented to ensure that care plan goals served the best interests of people. All care plans had been evaluated and reviewed on a monthly basis and more frequently where needs had changed. Care plan audits were also in place to ensure that documents contained all the required information relating to people's needs. Care plans included reference to people's ethnicity and sexuality but these were not always consistently completed. We raised this with the acting manager for action.

A complaints procedure was on display. This provided information for those people who wished to raise concerns and outlined the timescale for investigation. People told us that they did not have any complaints and that they were happy with the support they received. No complaints had been received by the service and our records confirmed that no complaints had been received by us. Compliments had also been received by the service. They included comments such as "We really appreciate your care", "You are such lovely staff" and "A special thank you for your exceptional care".

Good

# Is the service well-led?

## Our findings

While no one we spoke with gave a definite account of the way the service was managed, people told us that they happy with the care they received and considered that they were receiving a good standard of care and support from the service. This view was reflected by relatives' comments and the comments of a health professional.

The registered provider employed a manager who was registered with the Care Quality Commission. This person had been the manager of Stone House when it was owned by previous providers and the new providers had continued to employ this person to ensure continuity of care. The registered manager was not present during the day and was on a temporary period of absence. We had been notified of this prior to our visit. Arrangements had been made for a senior member of staff who had worked at Stone House for a number of years to act as the manager in the short term with the additional support of a registered manager from another service operated by the registered provider. This person was able to outline how they were managing the service to ensure continuity and demonstrated a commitment to providing a good quality of care to the people who lived there. Staff commented that they considered that continuity had been achieved with no disruption to the care and support provided. Staff told us that they considered the Registered Manager and the Acting Manager to be approachable and supportive and felt involved.

When required, the registered manager always notified the Care Quality Commission of adverse incidents or significant events which affected people who used the service. This was confirmed by our records. The certificate of registration was clearly displayed. This was the first inspection of the service since the new providers had taken over in 2016 and therefore there was no requirement to display ratings. The acting manager understood that the display of ratings would be a requirement in future.

The registered provider had sent questionnaires out to people who used the service, relatives, staff and other stakeholders such as health professionals. This had been done in 2016. The acting manager stated that new questionnaires were due to be sent in the near future. These last questionnaires had provided positive comments about the quality of care provided and the support given to the staff team. Meetings were held with people who used the service both on a group level as well as an individual level were issues unique to that person needed discussing. This ensured that people were able to be involved in the running of the service as much as possible or to discuss individual issues relating to their stay. Suggestions boxes were available throughout the building to invite people to comment on the service.

A number of audits were used to ensure that any improvements needed were actioned. Medication audits were in place outlining how effective the management of medication was and if any improvements were needed. External visits had been made by the pharmacy supplier to ensure compliance and the safe management of medication. In addition to this, accidents and incidents were analysed to look at preventing future re-occurrence. The registered manager submitted low level safeguarding returns to the local authority every month. Low level safeguarding are those incidents that do not meet the threshold for a full investigation. Further audits were available in respect of the environment. These extended to the safety of equipment as well as infection control measures within the building. The registered manager had

introduced a further audit to be completed by staff following every use of hoists. These checks included a visual check of the hoist as well as the safety of slings to be used. Records were maintained of each check. Care plan audits were also in place to ensure that care plans accurately reflected the needs of people.

Policies and procedures were available. These were up to date and had last been reviewed in March 2017.

Community links were maintained in certain aspects of the service. Health professionals were consulted in maintaining the health needs of people. A local community group had been invited to provide activities to people and links to the local church remained for meeting the spiritual needs of people as well as providing a place of safety in the event of the building needing to be evacuated.