Northern Care Homes Limited

Stoneswood Residential Home

Inspection report

Oldham Road
Delph
Oldham
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection of Stoneswood Residential Home on 29 June and 1 July 2016. We last inspected the home in July 2014. At that inspection, we found the service was meeting all the regulations that we reviewed.

Stoneswood is a large converted stone built building in Delph, near Oldham. It is sited on the side of a hill with views across the Pennine Moors. It offers accommodation and support for up to 41 people, all in single rooms. At the time of our inspection there were 40 people living at the home. The service is also registered to provide personal care to a small number of people living in their own self-contained flats attached to the care home. At the time of this visit, the service provider told us no one living in those flats was receiving any personal care provided by the service.

The home had a manager registered with the Care Quality Commission (CQC) who was present on the second day of the inspection. A registered manager is a person who has registered with CQC 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 and associated regulations about how the service is run.

We found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. We found that the home had not submitted applications for Deprivation of Liberty Safeguards for all the people who lived in Stoneswood who did not have the capacity to consent or object to their care and treatment. You can see what action we have told the provider to take at the back of the full version of the report.

We saw that great care was taken to ensure that people received the right medication and systems to manage medicines were safe. The staff worked in cooperation with other health and social care professionals to ensure that people received timely, appropriate care and treatment.

We found sufficient numbers of suitably skilled and experienced staff who were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for people safely.

People's care records contained detailed information to guide staff on the care and support to be provided. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and risk of injury.

The staff we spoke with had an in-depth knowledge and understanding of the needs of the people they were looking after. We saw that staff provided respectful, kind and caring attention to people who used the service.

We saw that suitable arrangements were in place to help safeguard people from abuse. Guidance and training was provided for staff on identifying and responding to the signs and allegations of abuse. All staff had access to the whistleblowing procedures (the reporting of unsafe and/or poor practice).

Mealtimes were a relaxed and social occasion with good interaction between people. Specific dietary requirements such as sugar free or soft foods were provided to people who needed them and staff were aware of people's dietary needs.

All areas of the home were clean and procedures were in place to prevent and control the spread of infection.

A fire risk assessment for the premises was in place and systems were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and gas supply.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided and there were systems in place for receiving, handling and responding appropriately to complaints.

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

A safe system of medicine management was in place.

Sufficient, suitably trained staff, who had been safely recruited, were available at all times to meet people's needs.

Suitable arrangements were in place to help safeguard people from abuse.

All areas of the home were clean and procedures were in place to prevent and control the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had not applied for DoLS for everyone who required one.

There were good relationships with local health care professionals and staff closely monitored people's health care needs.

Care was delivered by well-trained and knowledgeable staff who were encouraged to develop their skills through further training.

Is the service caring?

Good

The service was caring.

Staff had an in-depth knowledge and understanding of the needs of the people they were looking after.

We saw that staff provided respectful, kindly and caring attention to people who used the service.

People's privacy was respected and care records were stored

securely so that their confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

People's care records contained detailed information to guide staff on the care and support to be provided. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury.

The service offered a range of activities.

The registered provider had systems in place for receiving, handling and responding appropriately to complaints.

Is the service well-led?

Good

The service was well led.

There was an effective system in place to monitor the quality of the service.

There were regular meetings for staff, people who use the service and their relatives to raise issues, receive feedback, and share information about the home.

Stoneswood 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 29 June and 1 July 2016. The first day was unannounced. The inspection team consisted of one inspector. Before this inspection, we reviewed the previous inspection report and notifications that we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay.

We did not ask the provider to complete a Provider Information Return (PIR), prior to this inspection. However the Provider had submitted a PIR to the Commission in November 2015. A PIR 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.

During this inspection we spoke to five people who used the service, the registered manager, the assistant manager, four care workers, two housekeeping staff and the activity co-ordinator. We also spoke to a visiting health care professional and four visitors to people who used the service.

We looked around all areas of the home, observed how staff cared for and supported people and looked at food provision. We reviewed four people's care records, four medicine records, three staff files, the staff training plan and records about the management of the home.

Good

Is the service safe?

Our findings

People said they felt safe at Stoneswood. One person told us, "I feel safe and well looked after. I've no worries at all." A visitor told us "It's safe. The staff are very attentive and make sure the people are safe. Sometimes I stop and have a meal and I see they are watchful and know the residents' limits".

We saw that suitable arrangements were in place to help safeguard people from abuse. Inspection of the training plan showed all staff had received training in the protection of adults. The staff we spoke to demonstrated a good knowledge of safeguarding procedures and signs of abuse. The safeguarding policy and whistle blowing policies (the reporting of unsafe and/or poor practice) were on display in the entrance area of the service and were accessible to all staff. The Registered Manager informed us that there had been no safeguarding issues reported in the past two years. When we asked a member of staff about this, they told us, "We look out for people. We are here for them not visa-versa. If I saw anything bad happening I would certainly report it, but I have never seen any abuse". Another staff member told us that they felt all the staff were 'on their guard' to see any signs that people might not be happy, and told us that this could be an indicator of abuse. They told us that good handover of information and regular checks during shifts with constant communication amongst the staff ensured that risks of abuse were kept low. This person felt confident that they could speak to a member of the management team at any time if they suspected someone was being harmed.

We saw that care records were held on a centralised computer system and were thorough and detailed. We looked at four care records, which showed that risks to people's health and well-being had been identified for risks such as falls, moving and handling, pressure relief and nutrition. We saw that where risk had been identified a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks.

We observed staff supporting people in a way that kept them safe. For example, at breakfast we saw care staff supporting people to enter the dining room by linking arms and walking at a pace comfortable for the person. As they showed signs of fatigue, the care worker offered to stop for "a little rest".

We saw the front door to the home was kept locked. People had to ring the doorbell and, following staff ascertaining their identification and valid reason for requiring access, they were allowed into the home. This helped to keep people safe by ensuring the risk of entry into the home by unauthorised persons was reduced. When we arrived to announce our visit, we were asked for proof of identity before being allowed into the building. There was also a safety locking system in place on the front door; used to help prevent people who were considered as being at risk if they went out alone, from leaving the premises. The entrance area to the home was fresh, well lit and comfortable.

We were given access to the key codes within the building used by staff for accessing some of the rooms within the home. Some doors were locked to prevent people who used the service from entering other people's bedrooms and areas that could pose a risk to them if they entered alone.

We looked around all areas of the home. There were fine views across the Pennine Moors from a secure garden with features designed so that people with limited mobility could enjoy being in a therapeutic environment.

Bedrooms, dining rooms, lounges, bathrooms and toilets were clean. However, we noticed that some corridors were fitted with movement sensors, which meant that the lights would come on when they sensed a movement. This might be confusing or cause anxiety in the night to people who are living with dementia if they went into a corridor and the light suddenly came on. When we spoke to the provider and registered manager about this they agreed to consider the impact such lighting might have for people living with dementia

Communal areas and corridors were kept free of any clutter to minimise the risk of accidents. Health and safety risk assessments and checks for the building and equipment had been completed and were up-to-date.

There was lift access and two flights of stairs to the upper floors. The main stairway was wide with shallow steps but we saw that the second set of stairs, which led to an attic room used for storage, were steep and narrow. There was a safety gate at the bottom of these stairs but not on the first floor, where the stairwell could be accessed through an unlocked door. This placed the health and welfare of people at risk as they could stumble or fall on the steps. When we informed the assistant manager of our concerns they arranged to fit further safety gates and when we returned on the second day of our inspection these had been put into place.

We saw that where dangerous or hazardous equipment was stored, doors displayed warning signs and 'keep locked notices'. When we tried these doors, most were locked but we saw a fuse cupboard on the first floor had been left unlocked following a test of the call bell alarm system the previous day. When we informed the manager about this, she ensured that the door was immediately locked.

We saw bathrooms were pleasantly decorated in pastel colours to ensure that bathing would be a more pleasurable experience. Baths were equipped with temperature controls and bath chairs to help people get in and out. Communal toilets were well equipped. Soap, paper towels, disposable aprons and hand gel were available. Pedal bins with appropriate colour coded bin liners further reduced the risk of infection and cross contamination.

The service had systems in place to protect people and staff from infection and cross infection.

The laundry was well equipped with hand washing facilities, two washing machines and two tumble driers, which meant if one broke down laundry could still be carried out using the second machine. There was a sluice facility situated on the floor above the laundry area with a drop-hatch so soiled linen could be dropped into the laundry without cross contaminating any clean items. The sluice room was locked to ensure the safety of people who used the service.

We checked the kitchen and saw that it was clean and that the fridge temperatures were monitored regularly and food stored safely to prevent any risks of cross contamination or food wastage. A Food Standards Agency 'Food Hygiene' showed the highest rating of five.

Staff we spoke to understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such

clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

We looked at maintenance records and safety certificates, which were all in order. We saw that regular maintenance safety checks were made on safety equipment, such as the fire alarm, smoke detectors and emergency lighting. Other equipment used to support care staff with people's personal care, such as hoists, were regularly serviced to ensure safe operation. On the first day of our inspection the regular review and servicing of all the service's fire extinguishers, alarms and smoke alarms also took place.

A personal evacuation escape plan (PEEP) had been written for all the people using the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs.

We saw that the staff recruitment procedure in place gave clear guidance on how staff were to be properly and safely recruited. We looked at three staff files. These contained proof of identity, an application form that documented a full employment history, a medical questionnaire, a job description, two professional references and interview notes. This helped to ensure that only people with the correct qualifications, skills and experience were employed. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with vulnerable people.

Inspection of the staff roster and a discussion with staff showed there were sufficient suitably qualified and competent staff available at all times to meet people's needs. We were told the staff rosters were compiled according to the support needs of people who used the service. Dependency levels were regularly reviewed and if needs had increased we were assured that staffing levels would increase proportionately. During the day, there were five care assistants and one senior care worker, and four housekeeping staff a cook and kitchen assistant.. At night, the home had three waking staff on duty. We were also told that senior staff undertook 24-hour 'on-call' duties ensuring that staff were always supported.

Stoneswood has a medication policy to ensure the safe management of medicines. People who used the service told us they got their medication as necessary. The deputy manager carried out full medication audits on a monthly basis, and spot checks of medicines for three individuals each week. We saw that this system and the diligence of staff administering medicines meant that there had not been any medication errors reported.

Medicines were ordered by the deputy manager and delivered on a monthly basis by the pharmacy using a monitored dosage system with blister packs. This minimises the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Prescriptions were checked against delivery, signed for and countersigned to ensure that the appropriate medicines were delivered. Unused medicines and tablets were noted and stored in a returns box for returning to the pharmacy.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature, they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form, which records the details of any medicines prescribed, when they are taken and if they are refused. All medicines received were recorded on the MAR, which also included details of the medication, and dose required, a recent photograph of the person and details of GP, known conditions and any known allergies.

Medicines were administered by senior care staff who had received specific training on handling medicines, completed a competency questionnaire and demonstrated their ability to perform the task. We spoke with one senior carer who informed us that they had completed regular medication training and confirmed that they were happy with the training received.

We observed one medication round during our visit. The senior carer giving out medicines wore a red tabard to indicate that they were giving out medication. This meant that they would not be disturbed whilst handling medicines. Hand-wash and a paper towel dispenser were available on the medication trolley along with gloves and protective aprons. We saw that one person needed to have their medicine dissolved in a beaker of water. We watched this procedure and saw that as the carer waited, they knelt by the person's side to establish good contact and support, and explained to the person what they were doing. They allowed the person to take the drink in their own time and once they were sure that the drink was finished they recorded in the MAR chart that the medicine had been provided. Before each interaction with people who used the service the senior care worker would check the MAR chart unlock the cabinet, and take out the required medicines from the blister pack and empty them into a small container, which they offered to the person. Whilst watching them take the medicines, they talked and engaged with the person, and recorded the details correctly in the charts.

In some instances, we were told that medicines were given covertly. This is the administration of any medical treatment to a person in a disguised form, such as sprinkled on food or into a drink. Where covert medication was given the reasons and best interest decisions were documented on care records.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation is in place to ensure people's rights are protected. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS).

We saw that when staff were supporting people, for instance, with meals or with personal care, the staff were respectful and always asked for consent. Staff we spoke to understood that if people who used the service were unable to consent to treatment then a capacity assessment should be in place, but this was not always the case. It had been apparent in two cases that the individuals were objecting to their care and treatment, and the registered manager had submitted DoLS applications to the local authority. From our observations and discussions however, it was clear that there were other residents who did not have the capacity to consent or object to receiving care and treatment. The registered manager informed us that there were a further nine people who did not have the capacity to either consent or object to their treatment, and would therefore be subject to deprivation of liberty safeguards. Applications had not been made at the time of our inspection.

This was a breach of Regulation 11 (3) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. If the service user is unable to consent to care and treatment because they lack capacity the registered person must act in accordance with the Mental Capacity Act 2005.

When we spoke to people who used the service they told us they believed the care staff were competent and knowledgeable. One person commented, "They have a lot of training but I think it pays off. They all know what to do to make our lives more comfortable". A visiting relative felt that the staff also knew the needs of their relative. They said, "When [relative] needed a place to live, I was fearful at first….but needn't have worried because she settled so well. The staff have taken time with [relative] and know her well".

A discussion with the registered manager and some of the staff showed they had an in depth knowledge and understanding of the needs of the people they were looking after.

We looked at how staff were supported to develop their knowledge and skills. We were shown the induction programme that all newly employed staff had to undertake when they first started to work at the home. It contained information to help staff understand what was expected of them and what needed to be done to ensure the safety of the staff and the people who used the service. The focus of this induction was to get to know the people who used the service. When they started at the service new staff would spend time working alongside a more experienced member of staff 'buddy' to enable them to be introduced to and get to know the people who used the service.

We saw in the business plan that recruitment was based on values, not necessarily qualifications. This meant that they chose staff who exhibited the right characteristics for providing good care. The service

placed a high emphasis on continuous development and improvement and this included supporting staff beyond the basic training needs. All new staff were supported to complete the Care Certificate. This is a professional qualification, which aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care. Any existing staff who wanted to obtain this qualification were also encouraged to work towards this, and given time for any required study.

We looked at the training matrix. This is a table which outlines relevant training requirements and enables a quick check to see what training has been completed by each member of staff, or when any refresher training might be due. We saw that the staff had completed all essential training required. This included training in areas such as the use of restraint, safeguarding adults, first aid, medication, food hygiene and specialist training such as epilepsy and autism. When we checked staff files, we saw that training was also recorded, including copies of any certificates obtained. Supervision records also showed discussion of any training undergone and how this has been implemented in daily work, and considered the need for further training. Staff spoken with confirmed they received on-going training to help them support people properly. One senior carer informed us that they were considering commencing the QCF level 5 training: This is a qualification, which is an accredited award for health and social care, and replaces the previous national Vocational qualification (NVQ). Level 5 is awarded for leadership.

Staff also spoke about completing training in the Six Steps end of life care pathway, which is a programme of learning for care homes to develop awareness and knowledge of end of life care. They talked about how they found this learning useful and how they have been able to share the knowledge gained with other staff members.

We were told that 'handover' meetings between the staff were undertaken on every shift. We witnessed one handover meeting during our inspection and saw staff would go through person by person with an update, and provide relevant information about any issues or concerns. Handovers help to ensure that staff are given an update on a person's condition and behaviour and should ensure that any change in their condition has been properly communicated and understood.

Records we looked at showed that systems were in place to ensure that all staff received regular supervision meetings. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

Staff we spoke with confirmed that this information was correct, and a member of staff told us they welcomed their supervision, "It gives me a chance to air my views. I feel I am listened to and it helps build my confidence." The deputy manager also recognised the value of supervision as a learning tool. She told us "It is important to motivate staff and keep them motivated. Supervision is one way; it allows them to express their views and look at what can be improved".

People wanting to live at Stoneswood Residential Home were assessed prior to admission and a care plan detailing their support needs was developed. The manager told us that this was to allow a seven-day period for the staff to get to know the person. The person's care plan was reviewed on a daily basis to develop a fully informed plan of care. We saw in case records that these plans included assessments from other health and social care professionals where necessary.

People told us, and we saw documentation in care files, that the service supported people to see other health professionals when required. This included dentists, opticians and podiatrists. We also saw evidence of occupational therapist visits to assist people to maintain dexterity and maximise their independence.

The care files we looked at showed that attention was given to people's nutritional needs and skin integrity. We saw that Malnutrition Universal Screening tool (MUST) charts were used. People were weighed on a monthly basis to ensure that they were maintaining weight. We noted that where there were concerns about a person's weight they had been referred to the dietician for further advice and support and their weight was monitored on a weekly basis. Similarly, issues about mental health were monitored and the registered manager told us that they had established good working relations with the local mental health team. We saw in one care file that where a person refused to swallow, the service liaised with the mental health team and the dietician to formulate a plan of action to ensure the person's nutrition and hydration needs were met.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We saw that meal plans were in place and were displayed in the dining area. Staff told us that people could have something different from what was on the plan. People told us that they liked the food on offer and we saw that attention was paid to their nutritional needs. The kitchen kept a list of any special requirements for people who used the service, and care staff liaised closely with the kitchen staff to keep them informed of any changes needed.

We spoke to a visiting health professional who told us that the care staff were always welcoming and valued the support they were able to offer. They believed that staff were attentive to the health needs of the individuals who used the service. This person informed us that the staff and managers at Stoneswood worked closely with the surgery, monitoring all people, and would inform of any changes or differences in behaviour. If health staff advised any course of action to minimise risk or monitor progress, this was always followed up. They commended staff for their vigilance, "They are very good and alert, and will spot any early signs or changes in appearance which might be health related. This means there are very few emergencies and it prevents unnecessary hospital admissions. There have been no major incidents of pressure care because staff are proactive, so if any marks develop they will inform the surgery and ask us to assess." They told us that the service were equally good with palliative care, and would ask the GP (general practitioner) to regularly review any DNARs people had in place. If it is expected that a person's heart was to stop or they were to stop breathing as part of the dying process and cardiopulmonary resuscitation (CPR) would not be successful. The person can make an advanced decision not to attempt CPR. Such decisions are recorded on a Do not attempt CPR (DNAR) document and instruct medical teams not to attempt cardiopulmonary resuscitation (CPR).

Good

Is the service caring?

Our findings

We saw that Stoneswood had been voted as "The best care home in the North West" and in the top ten in the country, in a poll conducted by a large independent website. People who we spoke to felt this was partly attributable to its caring environment. One person who used the service told us "We did our research, and I am in the best place. I am always treated with dignity and respect by staff who really know about what I want and need." A visiting relative told us, "I have the highest regard for the staff. They are wonderful and caring, and I have never seen them treat the residents and their visitors with anything other than respect and kindness. I have not got a bad word to say about this place. They see to everything, for instance they make sure people are involved and are never isolated".

People told us that they got on well with the staff at the care home, and we saw that there was good interaction between the people who used the service and staff, who encouraged general conversation and social inclusion. For example, over lunch we heard conversation turned to a discussion about how people met their partners, and people were encouraged to express their views in a friendly fashion. We were told about an incident the previous night where reminiscence led to a general conversation about situation comedies, which ultimately led to a care worker finding an old DVD, which was put on for all to watch. People told us the following day that they had enjoyed their evening.

Relatives we spoke to also told us that they were made welcome. They informed us, and we saw that staff knew who they were, and were always welcoming. A relative told us that the staff were always available, friendly and knowledgeable. They told us "They are all approachable, and always know who you are, and how the person you visit has been. They show some really nice touches which show that their care is genuine". There were no restrictions placed on visiting times.

People told us that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported. Relatives agreed; one person told us "The staff are lovely and nice. They have developed a good understanding of [my relative], who is happy here. If we go out, [my relative] is always happy to come back. She has made new friends".

We observed staff treat people in a caring and compassionate manner. For example, we overheard a carer entering a bedroom to help a person who used the service to get up and dressed. The carer introduced themselves, addressed the person by name, and gently asked about the person's well-being. They continued to talk as they were assisting the person, offering choices in a meaningful way and helping them to choose appropriate clothing to match the weather.

When we observed lunch, we saw that staff offered to help anyone struggling to eat their food, and allowed people the time to finish their meals without rushing to clear tables.

We saw that staff addressed people by their preferred names, and spoke to them in an unassuming way, making eye contact and using touch when appropriate.

Staff formed positive relationships with people and demonstrated a good knowledge of their physical, social and emotional needs. People told us they thought the staff listened to what they had to say. One person told us, "They always have time for me. I know that they are very busy, but if they see me on my own they always come over and have a little chat". When we asked a member of the care staff about their work, they told us "I am proudest of the residents and how content and happy they are here, especially after they first come in, to see people who have been sad at home and not coping to come here and find a new lease of life".

People told us that they could express their views and that staff and managers listened to them. One person told us, "I am consulted on all aspects of my care, and can have full choice in what I want. If I vary my routine, the staff understand that and will accommodate me. Nothing is too much trouble". A relative of a person living with dementia told us "They consult with me and always ask if they notice any new behaviour with [my relative]. If there is anything wrong they tell me and call the doctors out."

We saw that care records were kept securely on a computer-based system with access available through a secure firewall. This ensured that confidential information was protected. The employee handbook emphasised the importance of ensuring the confidentiality of information was maintained by staff.

People's care records made clear when people required support and what they could do independently. People and their representatives were encouraged to discuss goals about what they would like to achieve.

There was evidence that people's wishes for their end of life care had been considered. The service has been certified as an approved "six steps to care for the dying" care home, and staff were knowledgeable about the appropriate care provision for people in the end stages of life. Information provided in care records included personal preferences, such as funeral plans, where appropriate.

We were told the cultural and religious backgrounds of people were always respected, and we saw that the staff had attended training in culture and diversity. However, there was nobody living at the home that required any special cultural or religious consideration.

Good

Is the service responsive?

Our findings

People told us that they were supported in the way they had agreed and that the staff knew what they liked and disliked.

When we looked at care files, we found they were well kept and reflected service delivery. We saw that care plans were amended as needs changed, and reviewed monthly, showing continuous change. Risk assessments showed consideration of risk and reflected needs, abilities and wishes and this was reflected in care plans to minimise or reduce risk.

Stoneswood have adopted a computer based electronic system to store all care files relating to people who use the service. Staff told us that they found the system easy to use. One person said, "I love it. It is so easy to navigate through, and we can keep everything up to date. You can read what people have written because it is all typed and there immediately. We keep it updated throughout our shift so when I come on I can get a really quick update of all the residents".

We reviewed the care plans for four people who used the service. We saw that changes in behaviour were documented. Where risk was identified, details were captured and care plans had been revised to reflect the status of the risk. The system allowed for detailed recording, which covered various contingencies and allowed information to be cross-referenced to allow for prompt and accurate completion of reports. For example, where a person who used the service was at risk of falls, we were able to track the history of the falls and see what action had been taken and when. Where falls occurred, each incident was recorded in the care notes and cross-referenced to the accident and injury log. Body maps, care notes and action plans were completed.

Care notes were accessible and up to date, and had been written in a way which reflected and gave a picture of the person whom they were about. We saw that the assessments were regularly reviewed and were thorough, identifying 22 domains such as care needs, personal history, rights and consent, advanced care plans, and nutrition and hydration. Each section could be further broken down so where issues were identified a plan would be put into place to respond. We saw, for example, a care plan documented under general health that a person had diabetes, and subsequent plans showed dietary needs, liaison with health visitors, and insulin administration. This system also provided filters for analysis, such as collating of accidents and incidents, number of falls by person or place. We asked to see a bathing record for one person and saw that this person had been recorded as having regular baths, with a commentary on each occasion.

There was information available for health professionals, such as hospital staff if required following an admission to hospital.

Records and care plans were written in a way which reflected the person's abilities and strengths but did not deflect from their needs. For example, "[Person] likes to be independent but occasionally requires prompts for personal care."

Care records for people documented their interests and what they enjoyed doing. People and their representatives told us that they were offered choice in the delivery of their care and support. We were told that there are no set times for people to get up or go to bed. A care worker told us that after supper people started to retire to bed and would ask for assistance when they were ready.

People were involved in planning and drawing up their care plans. Where people did not have the capacity to be involved in their care planning we were told that relatives were invited to assist with the process. Relatives we spoke to told us that they were always kept informed of any incidents that happened to people who used the service and that they were asked for their views on how to deliver care. However, this had not always been a smooth process. One relative told us, "It was a difficult start. I don't think that they realised we wanted help, not to give up on [relative]. We don't feel that we were always listened to, but now we've got a plan together and it's settling down".

People told us that there was enough to do. One person who used the service said to us "I like that there is something each day. We might decorate cakes and buns, I like that. We'll be doing painting this afternoon".

There were a variety of activities on offer to the people who lived at Stoneswood. The service employed an activity co-ordinator, who planned activities on a daily basis. An activities board in the main dining area displayed the weekly activities. These included visiting entertainers, carpet bowls, and art classes. In addition, Age UK Oldham operated a day care service for older people from the home twice a week. This service can be accessed by the local community and people living at Stoneswood, for a fee, if they wish to attend.

We spoke to the activity co-ordinator who informed us that she tried to get to know people and consider activities which might appeal to them, and recognised the need for a wide spectrum of activities. In general, she would try to provide activities to allow for some physical or mental exertion, and rotate on a daily basis, so that if there was a physical activity one day, such as keep fit, this would be followed by a more sedentary pastime, like quizzes or art and crafts.

The activity co-ordinator informed us that on occasion they would arrange to have lunch in a local pub, or visit a garden centre. She had also arranged to bring in volunteers to provide one to one support for people who did not want to get involved in-group activities. The registered manager explained that volunteers have always been welcomed, and in October 2013 Stoneswood co-operated in a pilot scheme organised by the National Council for Voluntary Services (NCVO) to identify, recruit, and train volunteers to 'buddy up' with people who used the service .
We saw for example that one person who used the service was regularly visited by a volunteer who shared their interest in aeroplanes, and would bring in pictures, DVDs and charts to promote conversation around their shared interest, or escort the person on trips to the airport. The service supported the volunteer by continuing to pay expenses for travel. We were told that this volunteer would also support the person to ask for assistance and liaise with staff when necessary. Although this pilot scheme has come to an end we were told that the Activities Co-ordinator has continued to use the training received to attract and support new volunteers.

We saw that a copy of the complaints procedure was on display in the main entrance, and people knew that they could make a complaint if they wished. One person who used the service told us, "If there was anything wrong I'd go straight to [the registered manager]! She'd deal with it straight away." A visiting relative agreed, stating, "I have not had cause to complain but if I did I am confident that [the registered manager] would sort it out.

We asked to see the complaints file and saw that the last complaint was made in February 2015. We saw that this complaint and others had been taken seriously with an appropriate response given outlining actions taken. We asked the registered manager about the low level of complaints. She informed us that complaints were rare, and as she had an 'open door' policy, she was often the first port of call when something appeared amiss, and would be able to resolve the issue informally before it became a serious issue.

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Stoneswood is registered with the Care Quality Commission. When we visited Stoneswood, the home had a registered manager who has been registered since 2010. The registered manager was present on the second day of our inspection.

A discussion with the registered manager and staff showed they were clear about the aims and objectives of the service. This was to provide a high quality service through continuous improvement and respect and development of people.

Staff told us that the registered manager was, "Very efficient, but approachable. She sets a high standard and we all try to meet that level because it is important to the people who live here". The staff we talked with spoke positively about working at the home. One staff member told us they believed there was a good team ethos, that the staff all got on and shared a common goal. Another told us that they appreciated the support and encouragement from managers who responded well to the needs of staff and of the people who used the service. The level of staff turnover was low; staff were cheerful and friendly and worked well together. Morale amongst the staff was high.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. We were told that regular audits/checks were undertaken on all aspects of the running of the service and were shown an audit schedule.

We looked at some of the audits that had been undertaken, such as care of residents, staffing, laundry and cleaning. We saw the audits were thorough and detailed. For instance, audits on care of residents covered all aspects of care files from pre-admission assessment to up-to-date notes, checking for updated and monthly reviews of risk assessments. The audits showed where improvements were needed and what action had been taken to address any identified issues.

Staff told us that they were involved in discussions about issues in service provision during staff team meetings and in individual supervision sessions. Staff meetings were held every three months, and minutes were typed and available for all staff to review. Where specific issues were identified, extra meetings were held. For example, a meeting had recently been called regarding cleaning duties and personal hygiene for domestic staff. Meeting minutes demonstrated that staff were encouraged to raise issues. Staff told us they found team meetings useful, and felt supported to raise issues and suggest changes they felt needed to be made.

We saw that where possible, people who used the service were given the opportunity to influence not only their care but also the management of the home. Individual one to one meetings with staff or managers allowed people to comment on the delivery of care and to look at the services within the home. Topics covered in these meetings included the facilities, food and dining choice, activities, standards, entertainment and improvements and suggestions. The service used this information to drive forward

improvements based on the satisfaction of the people who used the service. There were also residents and relatives meetings, which were minuted with actions taken in response to any concerns raised.

The service also sought feedback from relatives of people who use the service by distributing a questionnaire every six months. We saw that the most recent questionnaire showed that half the questionnaires were returned, and these showed a 95% satisfaction rate. Issues raised included seating, staffing levels at various times of the day and use of nametags for staff. We saw that action was taken to resolve or explain the issues raised.

The manager was aware of the importance of maintaining regular contact with people using the service and their families. Relatives meetings were advertised and relatives were invited to attend in order to feedback and share information about the home. Minutes were distributed to all named relatives. We saw that these meetings provided an opportunity to inform relatives of specific issues, such as Deprivation of Liberty Safeguards, The Care Pathway for the Dying, and Advanced Care Planning. The service also produced a regular newsletter to keep relatives informed and updated on events such as an upcoming fashion show.

The manager operated an open door policy and was available to privately discuss issues with relatives or people using the service.

We checked our records before the inspection and saw that accidents or incidents that the CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had not applied for DoLS for all people assessed as lacking capacity to make a decision