West Country Care Limited

# Stainsbridge House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Stainsbridge 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. The service can provide accommodation and personal care for up to 46 people at this location. At the time of our inspection there were 42 people living in the home. The inspection took place on 4 and 5 June 2018 and was unannounced.

At the last inspection on April 2017 we asked the provider to take action in response to the concerns found around staffing levels. The service was in breach of Regulation 18 Staffing. At this inspection we found that the service had met this previous breach, however a further three breaches of Regulations were identified. This is the second consecutive time that this service has been rated as requires improvement and we are considering what further action will be taken in response. Full details of CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The home did not currently have a registered manager in place. The previous registered manager had recently left the service and the deputy manager was in the role of acting manager. The acting manager was being supported by a registered manager from another of the provider's services and the director who were present throughout our 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.

Prior to this inspection we received concerns about the service which we asked the provider to investigate and report back to us. We further assessed these concerns during this inspection and full details of what we identified is in the main body of this report.

Medicines were not always managed safely. There were concerns identified regarding the safe use of prescribed fluid thickeners for people who had swallowing or choking difficulties.

Risk management and documentation to support identified risks was not always managed safely. For example, one person's support plan contained a body map, dated 24th May 2018, which recorded that the person had a bruise on their forehead. The manager was unaware of this; there was no further information in the person's daily record and it had not been reported as an incident or accident. This meant that the cause of the bruising had not been investigated.

During our inspection we observed staff were visible on the floors to support people. We heard call bell times answered in a timely manner and people and relatives felt the staffing levels were mostly good. Staff we spoke with however consistently told us they felt the staffing levels could be better. We observed on the first day of inspection that three people were walking around at 5:30pm in their night wear, which staff

attributed to staff shortages.

There was a lack of understanding around the appropriate process to follow for people who lacked capacity and were unable to consent to the care and treatment provided.

We found that some care plans lacked detail and person-centred information. Information relevant to the needs identified were not held together for staff to gain an overall picture on how to meet the needs. Monitoring records were not appropriately completed to ensure action could be taken in a timely manner.

Quality monitoring of the service was in place; however, it did not provide a clear rationale of what this attributed to the overall picture of the service. The previous registered manager had been quite insular in managing the documentation and due to this there had been a lack of provider oversight in the day to day running and how quickly improvements had been implemented.

People said they liked the food because they had a good choice and alternatives were available if they wanted something different.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

Staff demonstrated that they knew people well and supported people accordingly. People appeared comfortable around staff and were happy to approach them when needed. Relatives were happy with the care their loved one's received.

People were given the opportunity to provide feedback on the service they received. We saw that the service had received compliments about the caring nature of staff care and engagement offered.

You can see what action we told the provider to take at the back of the full version of the report. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

This service was not always safe.

Medicines were not always managed safely. There were concerns identified regarding the safe use of prescribed fluid thickeners for people who had swallowing or choking difficulties.

Risk management and documentation to support identified risks was not always managed safely.

Safe recruitment practices were followed before new staff were employed to work with people.

### Is the service effective?

**Requires Improvement**

This service was not always effective.

There was a lack of understanding around the appropriate process to follow for people who lacked capacity and were unable to consent to the care and treatment provided.

Staff did not always speak positively of the induction they had received on commencing employment. Staff had not all received regular supervisions, until recently when the acting manager had taken up their role.

People said they liked the food because they had a good choice and alternatives were available if they wanted something different.

### Is the service caring?

**Good**

This service was caring.

Staff demonstrated that they knew people well and supported people accordingly.

People appeared comfortable around staff and were happy to approach them when needed.

People's backgrounds and cultures were respected and encouraged. We saw that people were able to follow their

spiritual needs at Stainsbridge House or within the community if they preferred.

## Is the service responsive?

**Requires Improvement**

This service was not always responsive.

We found that at times care plans lacked detail and person-centred information. Information about people's needs was kept in several places which made it hard to gain an overall picture of that individual's needs.

Some people had monitoring records in place, if they needed support with eating, drinking or to change position. We saw that these records were not appropriately completed to ensure action could be taken in a timely manner.

People were encouraged to follow their interests and participate in daily life at Stainsbridge. People spoke positively about the opportunities they had.

## Is the service well-led?

**Requires Improvement**

This service was not always well-led.

Quality monitoring of the service was in place; however, it did not provide a clear rationale of what this attributed to the overall picture of the service

The previous registered manager had been quite insular in managing the documentation and due to this there had been a lack of provider oversight in the day to day running and how quickly improvements had been implemented.

People were given the opportunity to provide feedback on the service they received. We saw that the service had received compliments about the caring nature of staff care and engagement offered.

# Stainsbridge 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.

The inspection took place on 4 and 5 June 2018 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke to 15 people living at the home and eight relatives or visitors. We spoke with twelve members of staff, the acting manager, director of the company and a supporting manager. We also received feedback from five health and social care professionals.

We looked at the care and support records for ten people. We also looked at records relating to the management of the service including the staffing rota, incident and accident records and recruitment and training records. We observed care and support provided to people in the communal areas of the service.

Requires Improvement

# Is the service safe?

## Our findings

Medicines were not always managed safely. There were concerns identified regarding the safe use of fluid thickeners for people who had swallowing or choking difficulties. One person had a handwritten addition to their medicine administration record (MAR) for a prescribed thickening agent. Three care staff said that the person required thickener at the consistency of one scoop per 100ml of fluid. The thickening agents available in the home were for other people but not the one detailed in the MAR for this person. There was no documentation regarding the medical condition for using thickeners or guidance from a GP or speech and language therapist (SALT) for thickeners to be used in fluids.

It was recommended that the management conduct an immediate investigation in order to ascertain whether the thickener had been prescribed, was required, and whether another person's thickener was being used. It transpired that there was a prescription for this person but this had not been obtained. It remained unclear if this person had not been receiving thickener with their drinks or had been given another person's prescription. This person's medicines had not been safely managed which had put the person at potential risk.

Another person had been prescribed a thickener. There was no information in their support plan, such as a SALT assessment, relating to the type or amount of thickener to be used and no information on their food and fluid chart. The only reference to the amount was recorded on a handover sheet which stated this person was a 'Choking risk, Stage 3 thickener'. Staff were unclear what guidance they referred to.

Medicine storage fridges were in use and the maximum and minimum temperatures were recorded. Those recorded for the ground floor fridge were above the recommended temperature of 8 degrees Celsius on two occasions; and on the first floor on two occasions. The senior carer stated that this would have been reported to the maintenance person but did not record the action taken. We observed there were some gaps in the MAR regarding administration of two people's medicines. The reasons for not administering these medicines was not recorded on the MAR chart.

People told us that their "tablets" [medicines] arrived on time and staff waited and checked that they had taken them. The majority of medicines were supplied in a monitored dosage system pre-dispensed by a pharmacy. Any medicines disposed of or returned to the pharmacy were recorded in log books and signed by two staff members. We observed part of a medicine round and saw staff demonstrated an awareness of the needs and preferences of the people they administered medicines to. Topical medicine application recording sheets had been signed by staff following application and included body charts detailing the areas of application.

Risk management and documentation to support identified risks was not always managed safely. For example, one person's support plan contained a body map, dated 24th May 2018, which recorded that the person had a bruise on their forehead. The manager was unaware of this; there was no further information in the person's daily record and it had not been reported as an incident or accident. This meant that the cause of the bruising had not been investigated. This person's support plan also contained a moving and

handling assessment recording they required the use of a 'small sling'. However, their support plan for mobility stated that they required a medium sling, which did not concur with the moving and handling assessment. It was established that this person did require two types of slings, however this had not been appropriately recorded in order to be clear.

We saw examples of other risk assessments that identified risks but recorded no information on what action would be taken to minimise this. For example, one person had experienced episodes of choking on several occasions. We reviewed their care plan and saw there was no risk assessment in place, or information on what staff should do if the person began to choke. Another person's care plan recorded that they were at 'extreme risk' of falls on a falls assessment. There was no further details documented about the management and prevention methods to reduce this risk.

People who required pressure relief air mattresses had these in place. The required inflation pressure in relation to the person's weight was recorded on a sticker placed on the back of people's wardrobe doors. There was also a master copy in the pharmacy room on the ground floor. We checked the inflation pressures of all mattresses in the home and found four were set at incorrect levels. The manager was informed of this finding.

We observed one person coming down a set of stairs unsteadily without any shoes shouting for help. They were carrying a walking stick with them. We reviewed their care plan which stated they were at high risk of falls and assistance around mobilising was required. However, no staff had been present when this person had come down the stairs. A risk assessment from May 2018 was in place for using the stairs and had been discussed with a relative. It stated that staff should be aware of the risk and support person at all times. An entry to the person's mobility plan in May 2018 stated their mobility had changed due to environment and falls in that month. However, there was no mention of the person's walking stick. There was no information on how to minimise the risk of environment or precautions around the stairs. One staff told us "We try and not let [person's name] down the stairs as they have had several falls." The risks to this person had not been effectively managed.

In practice we saw that staff managed any anxious behaviour appropriately and diverted people taking time to reassure them. One person's emotional care plan stated to spend time, offer support and gently remind of circumstances. As a last resort administration of medicines would then be considered. However, the recording of incidents was not clear. For example, Antecedent-Behaviour-Consequence (ABC) Charts were used to record accidents and not for monitoring behaviour (ABC chart is a direct observation tool used to collect information about the events and presentation of an individual).

We saw that behavioural incidents were recorded in people's daily records but these did not consider patterns or outcomes. For example, we observed recordings including "At morning aggressive, declined pad change and personal care." No actions around the management and support of this were recorded. The provider policy stated a detailed record of incidents should be documented to review possible causes. The acting manager told us they were arranging for someone to visit and lead workshops around this topic area to inform staff.

For any incidents and accidents people had experienced, we found these were not fully documented. The acting manager told us a paper record was completed and then put online at which point the paper copy was destroyed. We saw that one person had experienced a fall in May 2018. There was a body map in place but the bruise they obtained during the fall was not recorded. The action taken in response stated, 'general check'. The acting manager said the online body map was not used and a paper copy would be put in the care plan, however , neither could not be found.

One person had received a fall and cut to their head. Initial action was taken and advice was sought from a GP but there was no evidence that ongoing monitoring had been undertaken in response to this person receiving a head injury. The acting manager told us they checked people after or for 24 hours but did not record this. We saw that the completion of these forms had been raised previously with staff in a senior meeting and a staff meeting. However, this had continued.

This was a breach of Regulation 12 (2) (a) (b) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was clear documented evidence to show when health and safety checks were carried out including water quality testing, electrical and fire safety and equipment tests .

At our last inspection in April 2017 the home had been in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not sufficient numbers of staff to meet the needs of people using the service. At this inspection although we saw that further improvements were still needed around staff deployment enough action had been taken to meet this regulation.

During our inspection we observed staff were visible were on the floors to support people. We heard call bell times answered in a timely manner and people and relatives felt the staffing levels were mostly good. Comments included "Yes, there is enough staff around if you need anyone. Never have to wait long", "Seem to rub along on low staff, it doesn't affect me, they will come eventually", "Always somebody here if we need them", "Enough staff, all very nice seem very caring. Caring is not just a job" and "On this floor you see the same staff, the night staff introduce themselves."

Staff we spoke with however consistently told us they felt the staffing levels could be better commenting, "The staffing is not enough, they have been interviewing. We are rushing until you go home, more recently staffing has been looked at. A lot of staff have left. Extra staff were brought in today and it made it more chaotic", "The ground floor needs three and there is only two at the moment. Someone should be in lounge as people are at risk of falling. On the middle and ground floor you don't get time to sit with people", "The middle floor needs skilled people, not the new people" and "We need more staff on the floor."

One staff told us "We definitely need more staff; some people don't have pad changes until later which is too long to be waiting in a dirty pad. We mostly cover physical needs but not their holistic needs, they need more. We only see people to give food or pad change. Staff were drafted in because of this inspection. We have residents that become aggressive and we don't have the time to take them outside and calm them down as not enough staff. We have raised this." A health and social care professional told us "I think that as a home they have a large number of residents requiring a high level of care which does I think put a strain on staff numbers.  I do know they have had problems recruiting and retaining staff."

We observed on the first day of inspection that three people were walking around at 5:30pm in their night wear. We spoke to staff about the reason for this and were told "It is early, it's to give them a pad change and help the night staff because we are short staffed. It should be done because it's their choice and not to suit us." We saw in May 2018 a relative had also raised their concerns around this when their relative was put into nightwear at 4pm. This concern had not been fully addressed and was still happening.

The home used a dependency tool to set staffing levels and provided above the required staffing hours on most shifts. We saw that one person's care dependency needs had not been updated, since 2012. Staff felt the level of needs of some people had increased which impacted on the levels of staffing. We saw staff spent

a lot of time supporting one particular person who would seek staff out for constant reassurance and away from their other roles needing to be fulfilled. The dependency tool had picked up that having one of the three staff on the middle floor administering medicines, was putting a strain on staff and action had been taken. The director explained that staff may be used to working with higher levels of staffing so when they run on their minimum staffing levels it feels less when it is actually correct. The director further said that the deployment of staff until recently had not been managed well, but this was now addressed and positive comments had been received.

We recommend that the provider considers the effective deployment of staff, or and revaluates the level of dependency needs within the service.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. The director told us "We are only advertising for experienced care staff, we do recognise and have a plan in place. We are going through a period of change and I feel better about Stainsbridge in the last few months."

People we spoke with told us they felt safe living at Stainsbridge House. Comments included, "I feel safe enough, people kind and around", "It's very good living here, everything correct, top place. It's safe, nothing worrying me at all" and "It's safe, I don't have any worries. They look after me fine." One relative told us "Absolutely safe and secure. To me it is good here. I know that when I am not here she is treated in the same way." Staff were able to explain what they would do if they witnessed or suspected abuse, including contacting outside agencies such as CQC or local authority safeguarding team. They felt that there was no form of abuse happening in the home.

We found the service to be clean and homely. Staff were able to explain how standards of cleanliness were maintained and cleaning schedules were in place to record the areas of the home that were being cleaned. Housekeeping staff were observed wearing personal protective clothing and using the correct colour coded cloths, buckets and mops to reduce the risk of cross contamination between high and low risk areas. People and their relatives told us the home was kept clean commenting "Very clean and tidy place. Laundry put it in the basket and it comes back the same day", "Any spillages cleaned up straight away. One day a person sent a drink flying. Staff came and mopped it up at once" and "It is nice, clean and tidy."

We spoke about the service reviewing the management of waste materials. The staff raised concerns about the current practice to place waste directly into people's en-suite pedal bins instead of the appropriate waste management bags. We were informed other methods of managing this had been trialled but it would be revisited to minimise the potential risk of infection control issues.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

There was a lack of understanding around the appropriate process to follow for people who lacked capacity and were unable to consent to the care and treatment provided. We saw the previous registered manager had identified people who were being deprived of their liberty. They had made 38 DoLS applications to the supervisory body. We reviewed the DoLS applications with the management team and saw that seven people had restrictions in place which had not been included or updated. This included sensor mats and bedrails. We further saw three people had no capacity assessments completed before restrictions were implemented.

The management present were unable to verify if these documents had been completed and could not locate them. This meant that people had been restricted without the appropriate legal processes being followed. After our inspection the director sent an excerpt from a DoLS application which referred to a person's sensor mat. This was not one of the people included in the seven that we reviewed at the time of our inspection. The supporting manager commented "We are going to get the DoLS team in to give [the new manager] some training."

One person's care plan contained a statement of 'No one available to consent.' Decision specific capacity assessments and best interest decisions relating to support plans were not recorded. It was noted that the person had two relatives, one of whom visited regularly, who could possibly have been consulted with regard to any best interest decisions.

Some relatives had given consent on behalf of a person but it did not record if the appropriate legal authority was in place for them to do this. The home had previously requested copies from relatives for Lasting Power of Attorney (LPA) and were still awaiting these to be brought in. However, they had accepted consent from relatives for things including bed rails, sensor mats and photographs being taken. During our inspection we saw letters being handed out for relatives to sign consent without the home first assuring themselves these relatives had LPA in place. We saw one person's care plan stated throughout that there was no one available to consent, however the person had capacity and was able to consent themselves. Another person was having their cigarettes kept by the home and had to ask staff when they wanted one. There was no consent recorded or capacity assessment in place for the management of this

Not everyone who lacked capacity had a capacity assessment completed. We saw one person's support

plan had 'No capacity' recorded. There were no mental capacity assessments in place to support this statement. The provider policy stated "If there is evidence that a resident lacks capacity, a capacity assessment should be carried out. Staff told us for one person they had to make daily searches of their personal possessions because of a specific condition they had. This practice was an invasion of the person's privacy and we saw it was not being conducted in line with best practice. There were no capacity assessments in place to guide staff, or evidence of a best interest's decision before this action had been decided. One staff told us "There is no assessment or rationale, they do not like staff checking their bag so it has to be done when they are not around." We raised these concerns with the management to address.

To access the lift between the three floors an access code had to be keyed in. We saw during our inspection people were not able to freely move from the upper floors without a staff member allowing them into the lift. There was no recorded information in people's care plans about this restriction including if they had the capacity to retain codes and if they were capable of using them independently. The providers response to people using the lifts had been a blanket approach. We raised this with the management to further consider.

The mental capacity assessments that were in place did not hold sufficient information on how a decision had been reached, or the person supported to understand the information. The assessments did not always have the name of the assessor recorded or the final outcome from this.

We could not find evidence of people being initially asked on preadmission if they consented to come and live at the home. One person's initial feelings of anxiety had been recorded but not if they consented to the move. For people who were unable to consent to this decision we saw that a DoLS application had not always been made in a timely manner. The supporting manager told us "We recognise that we need to source mental health knowledge."

This was a breach of Regulation 11 (1) Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to explain how they supported people who may lack capacity. Their comments included, "It's ensuring their right to have their wishes heard. It can depend on that moment, it doesn't mean they haven't got capacity" and "A lack of capacity means they can't make informed decisions themselves." We saw one person's mental capacity care plan stated they no longer had capacity to make decisions about their care and wellbeing but could make choices, daily of food and activities.

Staff did not always speak positively of the induction they had received on commencing employment. Comments included "The induction process was not positive, it left me feeling worse", "Induction shadow shift did not leave me prepared, I probably would have left if I hadn't already done care" and "The induction was only a couple of days. Luckily, I had experience so it was ok, it prepared me well enough."

We saw that an audit of staff files in May 2018 recorded that not all staff had received sufficient shadow shifts. A new induction pack had been put together for new starters going forward, containing two days of training including nutrition and care plans. The mentoring that new starters received was also been addressed as was not previously adequate. New staff were signed up to complete the Care certificate if they had not worked in care previously (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).

Staff completed most of their training online. A training matrix was in place which showed some gaps where training had not yet been completed or had expired but was in the process of being arranged. One staff member told us they had undertaken training modules on line, which included fire safety, moving and

handling, food hygiene and dementia awareness and were happy with the support they had received from other staff and the manager. We saw that staff were able to go on to complete higher level qualifications if they chose and the service afforded opportunities for progression to senior roles.

Staff had not all received regular supervisions, until recently when the acting manager had taken up their role. The provider's policy stated that every staff would have a performance review every 12 months and more supervisions up to one every 3 months. This had not happened. We observed gaps for some staff of ten months and one year where they had not received supervision. One staff told us "I spoke about supervisions with the previous manager as I didn't think it seemed enough." The acting manager had now started to ensure all staff had regular supervisions and was starting to pick things up and raise them with staff. Care competencies were also starting which would focus on staff assisting people with moving and handling, personal care and communication.

We observed that staff supported people appropriately and in a safe way. Staff were mindful to explain what they were going to do and reassured the person during the support. People and relatives felt confident with the skills staff had commenting "They look after [relative name] very well. [Relative] depends on a hoist now, there are always two staff to make sure she is taken care of" and "Staff know what they are doing, very good." One health and social care professional told us "This care environment specialises in Dementia care, with the addition of physical frailty. The various aspects and levels of dementia are manifested here and the staff not only show empathy and gentleness to the residents, but also awareness of the impact this has upon family and friends that visit…"

People said they liked the food because they had a good choice, it was the kind of food that they enjoyed eating and that it was well cooked. They told us that alternatives were available if they wanted something different. People told us "Very good food for a place with lots of people, very good and plenty of it" and "Food is fine. Always a choice of two things on, it's nice food. I like salad and you get options with it, salmon or chicken, they will do me one." One relative told us "Beautiful food, they are well fed, all locally made here. Eats what she likes. Cakes and plenty of fresh fruit. There are alternatives, you can go to the kitchen and ask for a yoghurt etc."

People had a choice of where they had their meals. Some people chose to eat in communal areas, seated at tables, others preferred to eat at individual tables and some ate meals in their rooms. People who were unable to leave their room were supported by staff during mealtimes. During lunch staff were on hand to serve meals and help people who needed additional support. People were offered hot and cold drinks throughout the day. For people that needed specialist textured meals, we saw these were presented in an appetising way. Moulds were used to give a realistic appearance to the meal. One relative told us "'The food always looks nice." One person said, "I enjoyed my dinner today, really tasty and nice and fresh."

People had access to health and social care professionals. A GP visited twice a week and the home spoke of the positive relationship they had with other health professionals including the district nurses. One relative told us how staff supported their family member around their specific health condition commenting, "Staff have received extra training in [health condition subject] since Mum has been here." One health and social care professional told us "I have confidence in the staff working at Stainsbridge house. They have good knowledge of their residents. The staff I meet do their best to meet resident's specific health needs and specialist help when needed.

The environment of the service was homely and had given some consideration to features to aid people living with dementia. For example, memory boxes were displayed outside people's bedrooms with memorabilia that was personal and significant to each individual. This helped to orientate people to their

room. We saw that the toilet seat in place was of a different colour to ensure that it was more easily recognisable to people who may have sensory impairments. The environment around the home afforded choices of where to spend time with a lounge and dining space on each floor. People told us they were able to personalise their bedrooms commenting "Very nice room, got everything I need in it. I like the high ceilings and feeling of space" and "It's a lovely comfortable room. I like to spend most of my time in my room, I prefer that."

People could access the gardens freely from the ground floor, however people on the upper floors were restricted using the lift without a staff member to activate the key code. We discussed this restriction with the director who is going to consider it further. One person told us "I spend nearly all my time outside in the garden."

Good

# Is the service caring?

## Our findings

People told us they were happy with the care they received and the staff that supported them. Comments included "Staff are kind and funny, we laugh a lot. Who wants miserable staff looking after you", "Staff are very good, I know them well and they know what I need, very good", "I don't worry about living here. Staff are very kind and very careful" and "Staff are caring. Care is very good. Sometimes we will sit and chat."

Some people living at Stainsbridge House had complex health needs. Staff demonstrated that they knew people well and supported people accordingly. For example, one person who had Dementia was observed becoming anxious and this was affecting some other people nearby. Staff discreetly stepped in to offer reassurance and diffuse the situation appropriately.

People appeared comfortable around staff and were happy to approach them when needed. Staff were knowledgeable about people, their past lives, likes, dislikes and how they liked to be approached. For example, a member of staff was able to describe how one person preferred to be communicated with.

Relatives praised the care their family members received commenting "The thing I like most about here is just how caring the staff are. They are very responsive [to care needs] so caring and reassuring", "Staff are friendly, overall very caring and attentive. Kind, thoughtful and understanding. If I see anything wrong I say so and small things are dealt with", "I have absolute confidence in the staff's ability. Now I have peace of mind" and "All good. I come in and out at all hours so I would see things if the care wasn't right."

Staff expressed genuine care for the people they supported. One staff told us "I enjoy looking after the residents, that's why I do this, I really like it. I put myself in their shoes." One health and social care professional said "I certainly do have full confidence in the various staff at Stainsbridge House. They show respect, adhering to their training on privacy, personal space and awareness of individual residents' respective personal needs with kindness."

People who were able to make decisions about their care told us they were involved on a daily basis. People commented "No restrictions, I get up, go to bed, go to my room, all when I want to", "I spend most of my time outside. I go out when I want. Staff ask if I want to do something, they listen to me" and "There is a lovely male staff here. We can say who we would like to give our care."

At times the spoken terminology from staff about people, was not always dignified. We heard people who needed supporting referred to as "Needing to be done" or being called "Sweetie, poppet and darling", which was not recorded in care plans as their preferred choice of reference. We saw a supervision record in May 2018 had already identified this and reminded staff to use the correct terminology.

All other observed interactions were respectful. Staff knocked on people's doors and asked if it was alright to enter. Staff approached people in different ways, indicating that they knew how people liked to be treated. People told us "Staff always speak nicely to me. They knock on my door before they come in", "I like to leave my door open, but they still knock on it" and "Very much dignity and respect, they knock on doors, support

me with care and are careful to ask." An information board in the home displayed statements to follow to uphold people's dignity.

People's backgrounds and cultures were respected and encouraged. We saw that people were able to follow their spiritual needs at Stainsbridge House or within the community if they preferred. Holy communion services were held fortnightly in the lounge area for people who wished to attend or offered on a one to one basis in a person's room. One health professional told us "The staff themselves represent a diverse ethnic and cultural identity and have a full understanding of the respect of those to whom they provide care and support."

Requires Improvement

# Is the service responsive?

## Our findings

People's care plans were kept electronically and paper copies in some people's bedrooms. We found that at times care plans lacked detail and person-centred information. Information about people's needs was often kept in several different places which made it hard to locate and gain an overall picture of that individual's needs.

For example, one person's care plan stated, "Encourage to eat and drink." There were no details of their favourite foods or drinks; how and when they liked to eat; or whether their food and fluid intake was being recorded. A list of people's dietary requirements was seen in the pharmacy room. This contained more specific information such as 'may need to put a fork or spoon in (person) hand to prompt them.' Further information was also recorded on the handover sheet, but not for everybody. The information had to be searched for in different places to get a complete overview of the person's nutritional needs. There was also no correlation between the paperwork to direct where further relevant information was kept.

Some person-centred information was recorded in care plans such as "Pillow to support on left side", "Bathroom light on at night" and "Likes to look after the garden." Other information however was vague or used language that reflected a non-person-centred approach. Examples of this included "Monitor urination", "Issues with personal care", "2hrly toileting" and "Toilet during the day.'' The acting manager told us "We are in the process of updating the care plans and making the more person centred."

One person was observed frequently going into other people's bedrooms. We saw their care plan stated they were also unsettled at night, however there was no detail of how this person was supported at this time or if extra checks were in place. One staff told us "The care plans, we don't get time to look at these. They have got better since [acting manager name] is on board. We learn from the residents about their needs."

Reviews of care plans contained little guidance on how to deliver care and treatment where people's needs changed. For example, one person's dementia care plan review stated they required more assistance. However, there was no information on what this might be and how staff were to offer this. Another person's review of their nutrition intake stated the person's weight fluctuates, but no solutions were detailed on how to support this person maintain a healthy weight.

We observed that daily records often appeared task focused. A tick sheet recorded if a person had received a bath or shower and been to the toilet each day. We saw staff recorded comments including "Seems to be constipated", "seems ok today no concerns", "Assisted by night staff and remains distressed and walking about" and "remains unimpressed and upset, been walking around all day." No further actions were recorded of what had been done to support people.

Some people had monitoring records in place due to being at risk of malnutrition, dehydration or pressure ulcers. We saw that these records were not being appropriately completed to ensure action could be taken in a timely manner.

The records of people's food and fluid intake did not always indicate that they received regular meals and fluids. One person's fluid intake for the two days prior to the visit indicated they had drunk 725ml and 800ml respectively. Other charts from May 2018 recorded daily totals ranging from 80ml to 600ml. A chart kept in the pharmacy room showed the recommended fluid intake for this person had been calculated as 1453ml per day. This had not been entered on the fluid chart in order for staff to be aware of the target. Another person had lost weight recently and their appetite had decreased. We saw one recent entry stated for the whole day they had received toast and marmalade and 200mls of tea and nothing else. The totals on the fluid charts were not added up and there was no evidence staff were noticing or raising concerns when people had eaten or drank significantly under recommended amounts. There were two days where this person's record had not been completed at all. This meant the monitoring charts were ineffective to support the risks identified to people.

People had recordings of the amount they had eaten listed as a number. There was no explanation on the food chart for staff to follow or indication of what the number meant. We found a sheet in the pharmacy room with a pie chart of numbers to represent how much of a meal a person had eaten. This was hard to follow as there was no information on the portion size how much a person had been given to start with. On one day a person had recorded lunch as one and supper as zero. According to the chart this meant they had only eaten a tiny fraction of their meal and then nothing in the evening. Some entries did not record how much a person had eaten. Another person had a recent entry of no breakfast, lunch nil eaten, 50mls of juice and nothing else for that day. The documentary evidence did not show people's needs were being met.

Some people required support to change their position regularly to minimise pressure ulcer risks. This was not documented appropriately. Staff told us everyone who needed repositioning was on two hourly turns. This was not a person-centred approach in line with individual need. One person's support plan and handover sheet stated that they required repositioning two hourly during the day and four hourly at night, in order to lessen the risk of developing pressure sores. We saw that the person had their position changed every four hours at night; however, there were no entries between 08:30 and 18:30 on the day prior to the inspection and no entries during the day on the previous record. There were also long gaps in recording seen on charts dated 24th, 25th and 26th of May 2018. This was evident across other people's records that we checked where gaps of up to 12 hours were observed. No one in the home currently had a pressure ulcer, however it was not known if people were being supported to change their position or this was a recording issue.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff told us "Staff do need to remember to do the paperwork." The acting manager was aware of this concern and had devised a form which they were about to put in place. The form instructed team leaders to complete checks during their shift and to sign that these had been done. The checks included cream charts, monitoring checks and Air mattress checks.

We saw that people had their communication needs recorded in care plans and one we observed had detailed information. The care plan stated "offer support when they are more anxious and ask the person to sit down and calm a little before they try to speak. We saw one person had an "enriched" model of care plan stating about the type of dementia they had, their personality traits and background information for staff to be aware of. The acting manager had started to re-write some parts of people's care plans to include more person-centred information and the examples of these we saw were much clearer and informative. The deputy manager had also started to put in place "My day" profiles in care plans so that staff could have quick glance information about things important to each individual.

People and relatives told us they were offered the opportunity to be involved in care decisions commenting "I can do everything for myself but they do ask me from time to time about my care plan", "I have been through the care plan, not for a while though. I think they would listen if I wanted anything to change" and "Taken through the care plan talk to staff about this and that."

Not everyone's care plan we looked at had information on their end of life wishes. For people that did have this in place, we saw this was mostly about funeral arrangements, rather than how they wished to be cared for and supported at this time.

The programme of activities was overseen by a full-time coordinator, supported by other part-time activity staff. This enabled activities to be offered seven days a week and brought a variety of skills to the programme. For example, one staff member was a musician and would bring in instruments at the weekend. People were encouraged to follow previous interests and participate in daily life at Stainsbridge. Several people with an interest in the garden helped with planting and daily maintenance. One person liked to wash up the cups and plates, whilst others laid the tables in preparation of meals. During this inspection a tea party was held in the garden for people to celebrate the Queen's birthday.

People spoke positively about the opportunities they had commenting "There is enough to do here. I join in with as much as I can", "I go out in the garden a lot. People come in to entertain us, have a good sing and I do the exercises" and "I join in with most things. The entertainment is good, there is a lot going on." 'One relative commented "Always happy when Mum is out of her room, feels buzzy, lots happening." One health and social care professional told us "I have been visiting Stainsbridge House for over two years. The staff know me by name and always greet me and I am invited to join in some activities" Another health and social care professional commented "The activities lead is excellent and social events and activities are well organised."

Records were kept which detailed residents' involvement in activities. Staff described how for some people the activities had a positive impact on their wellbeing. For example, one person did not join in with anything prior to living at Stainsbridge House but now enjoys the activities on offer. Staff told us the person's family were pleased to see this transformation in their relative. Links with the community had been developed and volunteers from a local school had spent time gaining experience in Stainsbridge House. Pupils from a local primary school also have visited and performed to people in the home at Christmas and Easter times.

People's concerns and complaints were encouraged and investigated. The complaints procedure was displayed in the building and outlined how to make a formal complaint and if necessary how to escalate them to the provider and beyond. People and their relatives felt happy that anything they raised would be addressed commenting, "Anything wrong and I would let [named staff] know straight away. Not needed to complain yet" and "I am sure they would listen and put anything right but I have no worries about anything." One health and social care professional commented "The manager and staff are approachable and do their best to deal with any concerns or queries I raise."

Requires Improvement

# Is the service well-led?

## Our findings

The home did not currently have a registered manager in place. The previous registered manager had recently left the service and the deputy manager was in the role of acting manager. The acting manager was being supported by a registered manager from another of the provider's services and the director who were present throughout our inspection. The acting manager was very open and honest about their new role and felt that it was a "big job" they had taken on.

Despite quality assurance and audit systems in place these were not effective as the administration of medicines was unsafe and care plans did not always record the needs of people adequately. The acting manager had not previously been involved in the quality monitoring or auditing of the home when they were in a deputy manager position. For this reason, it took a while to establish what was in place and what this information meant. For example, we saw one action plan from April 2018 stated care plans were 90% and so were risk assessments. There was no information or understanding of what this meant, if it meant 90% of care plans were in place or 90% needed improvements. The supporting manager and director were unable to explain this either stating that the previous registered manager had their own system for this which they did not adopt. Although we saw that similar findings to our inspection had been identified, the actions to follow up were not always recorded or taken in a timely manner.

A documentation and records audit from November 2017 was in the form of a tick chart but gave no information on what the findings were. There was a comment recorded for food and fluid charts which simply stated "OK." A medicines audit in November 2017 noted that there were missed signatures on medicine records. A more recent medicines audit in April 2018 also highlighted that there were continuing gaps. Although this had been picked up twice there was no details of action taken and we saw that this had continued during our inspection. The medicines audits were not comprehensive in their format and did not consider medicines that required extra security, people who may be self-administering or documentation and protocols around medicines taken 'as required'.

A falls audit in April 2018 had identified that improvements need to be made and that not all incidents had been followed up. This was in line with what we identified on our inspection but improvements had not been made within this timeframe. An audit for risk assessments dated April 2018 stated the home was meeting expectations and that bed rails and pressure mats had been accurately risk assessed and evidence of consent available. However, this was not in line with what we identified during this inspection.

A staff survey had been completed in 2017. A more recent survey this year had been completed, however this could not be located. One staff disclosed during the inspection that only half a dozen responses had been received and one comment to improve the service had been to change the management.

There was confusion around the documentary evidence in the home, in terms of what was in place and where it was located. The present management informed us that the previous registered manager had been quite insular in managing the documentation relating to the running of the home. Now that this [registered] manager had left the home processes were being introduced on managing this. However due to this

management style there had been a lack of provider oversight in the day to day running and how quickly improvements had been implemented. Staff understanding around completing documentation had been identified previously but action was only now being taken since the acting manager had been in post.

This was a breach of Regulation 17 (2) (a) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director told us they were aware of the areas that needed improving and showed us the action plan they had in place from January 2018 which identified some of the concerns we also found. The acting manager had also been given a recent action plan which they were now working towards with support. The director told us "[acting manager name] has only been doing the job for a week, we are monitoring her, the staff want her to do it. We want to make sure she is ready for it, she is committed and well liked." Plans were in place to support the acting manager and complete further training, including a dementia course and a management and leadership course. One staff member told us "Staff support is a lot better with the new management, it already feels better. The idea is there, but we need more guidance and to make an action plan and follow it through." The supporting manager told us the service now needed to formalise the action plan and know where they were going, in terms of specialising the service and increasing the knowledge of dementia. Two new employees had also been offered posts during our inspection who were described as having enhanced knowledge around these areas.

People and relatives told us that they were aware that the previous [registered] manager had left and seemed to be aware that the deputy manager was now the acting manager. Comments included, "We do know who the manager is, we chat to her", "The manager will come in and chat from time to time" and "I don't really know who the new manager is, there is a bit of a communication issue." We saw that a letter had been sent out to inform people of the new management arrangements.

Staff told us they felt better supported since the recent changes in management had taken place and praised the acting manager saying, "We struggled with the previous manager, [acting manager name] is more proactive and approachable", "I feel supported now, previously the manager was too busy in the office. [acting manager name] is on the floor", "[acting manager name] is approachable, I can go to her, we have got a good team" and "I feel recently I am supported, before I wasn't supported. [acting manager name] is someone I can go to and she will listen." Health and social care professionals told us "The manager was very approachable and frequently in contact with me" and "The manager is very approachable and the staff have been very positive regarding her input."

The acting manager told us she felt well supported by the director, supporting manager and staff team and there had been improvements including staff sickness reducing, hospital admissions reduced and positive feedback from families. One health and social care professional told us "The acting manager has certainly been extremely approachable and has provided me with information whenever required. She invited me to attend a staff training session recently, with the view of sharing my perspective."

People were given the opportunity to provide feedback on the service they received. We saw that the service had received compliments about the caring nature of staff care and engagement offered. We saw the comments from a survey completed in March 2018 which spoke positively about the service. A relative's survey from May 2018 praised the activities available in the home and the friendly and polite service staff gave. Relatives told us they felt involved in the service commenting "They will be on the phone straight away if anything has happened, or if the GP has been in", "There is an open culture, they let us know if there are any issues" and "If anything goes wrong they will phone me straight away."

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<br><br>There was a lack of understanding around the appropriate process to follow for people who lacked capacity and were unable to consent to the care and treatment provided.<br><br>Regulation 11 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not always managed safely. There were concerns identified regarding the safe use of prescribed fluid thickeners for people who had swallowing or choking difficulties.<br><br>Risk management and documentation to support identified risks was not always managed safely.<br><br>Regulation 12 (2) (a) (b) (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality monitoring of the service was in place; however, it did not provide a clear rationale of what this attributed to the overall picture of the service<br><br>The previous registered manager had been |

quite insular in managing the documentation and due to this there had been a lack of provider oversight in the day to day running and how quickly improvements had been implemented.

Care plans lacked detail and person-centred information. Some people had monitoring records in place, if they needed support with eating, drinking or to change position. We saw that these records were not appropriately completed to ensure action could be taken in a timely manner.

Regulation 17 (2) (a) (c)