

Care UK Community Partnerships Ltd

Stanley Park

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 6 September 2017 and was announced.

Stanley Park provides care and accommodation for up to 71 people, some of whom have a dementia related condition or require nursing care. On the day of our inspection there were 59 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Stanley Park was last inspected by CQC in February 2016 and was rated Requires improvement overall. At the inspection in February 2016 we identified the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 (Person-centred care)
Regulation 15 (Premises and equipment)
Regulation 18 (Staffing)

At this inspection we checked to see whether improvements had been made and we found improvements had been made in all the areas identified at the previous inspection.

Accidents and incidents were appropriately recorded and investigated.

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

Procedures were in place to ensure people received medicines as prescribed.

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

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

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

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

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

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

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

An effective complaints procedure was in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

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

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

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

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

Is the service effective?

Good ●

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff with their dietary needs.

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

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

Is the service caring?

Good ●

The service was caring.

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

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

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

Is the service responsive?

The service was responsive.

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

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

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

Good ●

Is the service well-led?

The service was well-led.

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

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

The service had good links with the community and other organisations.

Good ●

Stanley Park

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 6 September 2017 and was announced. One adult social care inspector carried out this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch, who is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

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

During our inspection we spoke with four people who used the service and four family members. We also spoke with the registered manager, deputy manager, regional director, operations support manager and five members of staff.

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

We carried out observations of staff and their interactions with people who used the service. We used the

Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to talk with us.

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe with staff at Stanley Park. They told us, "Very safe" and "Absolutely, it's safe."

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

We discussed staffing levels with the manager, looked at staff rotas and observed staffing levels within the home. The manager told us agency staff were used occasionally, this was mainly agency nurses on night shift. They also told us recruitment was ongoing all the time and permanent staff were very flexible at covering shifts. We found staffing levels were sufficient to keep people safe, call bells were answered in a timely manner and no concerns were raised by staff, people or visitors regarding staffing levels.

The home was clean, spacious and suitable for the people who used the service. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. This meant people were protected from the risk of acquired infections.

Accidents and incidents were recorded and analysed to identify any trends. A monthly report was produced and specific analysis of falls was carried out. Each person had their own accident and incident monitoring form, which recorded details of accidents and what interventions had taken place. We saw care plans and risk assessments had been updated with this information.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. Risk assessments included control of substances hazardous to health (COSHH), infection control, moving and handling, continence, risk of falls, first aid, lone working, and activities. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

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

Equipment was in place to meet people's needs including hoists, pressure mattresses and cushions, and

wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy. Appropriate action had been taken following any incidents or allegation of abuse. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The manager understood their responsibility with regard to safeguarding and staff had been trained in the protection of vulnerable adults.

We looked at the management of medicines and saw staff were appropriately trained in the administration of medicines and received annual competency checks.

Medication administration records (MAR) we viewed were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration.

We identified that the temperature in the ground floor treatment room was regularly one degree above the recommended safe storage temperature. However, this had been identified as part of the provider's quality assurance and auditing process. The manager told us a portable air conditioning unit had been requested and would be delivered shortly.

This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People told us, "It's good, no complaints" and "I'm well looked after." Family members told us, "I'm here every day. They do a good job" and "Everything is fine. I don't have any problems."

At the previous inspection it was identified that staff did not have regular supervisions in line with the provider's policy. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. At this inspection we found staff received regular supervisions and were fully appraised in their role.

New staff completed an induction programme and completed mandatory training. Mandatory training is training that the provider deems necessary to support people safely. The training included dementia awareness, fire safety, food safety, health and safety, equality and diversity, prevention of pressure ulcers, safeguarding adults, mental capacity, COSHH, diabetes, medicines, and moving and handling. We saw the majority of mandatory training was up to date and where it was due, it was arranged or planned.

People's eating and drinking support plans described their individual preferences, the level of support required at meal times and any specific dietary requirements. For example, support plans described whether people were at risk of malnutrition. We saw referrals had been made to health care professionals such as dietitians and speech and language therapists (SALT). Guidance from these professionals was included in the support plans and appropriate risk assessments and malnutrition universal screening tools (MUST) were in place. MUST is a calculator used to establish nutritional risk.

We observed the lunch time experience at the home and saw it was a calm, unhurried experience. Staff wore appropriate PPE and provided support to the people who required it. People had a choice of meal and were able to eat in their own bedrooms if they preferred. People and family members we spoke with told us the food was good.

Communication support plans described people's individual communication needs and what was expected from staff. For example, one person's support plan stated, "Allow me the time to communicate my needs." Staff were asked to speak to the person in a clear tone and encourage conversations about a subject the person was interested in.

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

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

called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had a good understanding of their legal responsibilities with regard to the MCA and DoLS, and maintained a DoLS matrix that recorded when a DoLS had been applied for, when it had been authorised and when it was due for renewal. Staff had been trained in mental capacity and any decisions made in a person's best interest were appropriately documented in the care records.

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

Some of the people who used the service were living with dementia. At the previous inspection it was identified that the premises was not suitably adapted for people with dementia. At this inspection we looked at the design of the home and saw communal bathroom and toilet doors were painted a different colour and were appropriately signed, and walls were decorated to provide people with visual stimulation. For example, tactile objects were attached to walls and included bags, locks and handles. Walls were decorated to look like shop fronts and there were pictures of London buses and telephone boxes. Memory boxes were on the walls outside people's bedroom doors, and people and family members had chosen different items to be placed inside them.

Carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. Corridors were clear from obstructions and well lit, which helped to aid people's orientation around the home. This meant the service incorporated environmental aspects that were dementia friendly.

Is the service caring?

Our findings

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way. For example, we observed a member of staff approach a person who was walking in the corridor. The staff member said, "Hello [name]. Are you ok pet?" The staff member then escorted the person to the lounge.

We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records described how people's privacy was to be respected and dignity promoted. For example, "[Name]'s privacy and dignity to be maintained", "Staff need to explain reassuringly and calmly that it is time to get washed and dressed" and "[Name] likes to be well presented and can often be found brushing her hair."

We saw a recent letter from a family member that stated, "When we have visited [name] we have seen genuine affection being given and received by many of the carers, and we have always felt that [name] has been treated with dignity and genuine friendship in her time at Stanley Park." A letter from another family member stated, "The staff excel in their care and consideration towards the residents."

Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Care records described how people were supported to be independent. For example, with mobility, eating and drinking, and carrying out personal care. We observed staff supporting people when required but people who were able to could mobilise independently around the home, and eat and drink independently at meal times. When people required support, staff were on hand to provide assistance and reassurance. Care records described people's level of independence and the support they required. For example, "[Name] is able to independently use the toilet, however, may require the assistance of staff in the event of incontinence" and "[Name] is able to complete some tasks with minor physical and verbal assistance/guidance." A person who used the service told us, "I look after myself." This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

There were no restrictions on visiting at the home and all the people we spoke with told us they could have visitors whenever they wished. Family members we spoke with told us they were always made welcome.

Advocacy information was made available to people and visitors. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The manager told us none of the people using the service at the time of our inspection visit had independent advocates.

The provider's residents' guide stated people's religious, cultural and spiritual needs would be fully

respected and facilitated by staff. In the care records we looked at, we saw people's needs in these areas were documented in their activities and end of life care plans.

End of life care plans were in place for people as appropriate and described people wishes regarding their end of life care and funeral arrangements. Records also included whether the person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Details were also provided on who to contact in an emergency. This meant people had been able to be involved in planning their end of life care.

Is the service responsive?

Our findings

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

At the previous inspection it was identified that people's care records were not always person-centred. At this inspection we saw care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Support plans included active living, administration of medicines, communication, eating and drinking, end of life, mobility, personal hygiene, prevention of pressure ulcers, and sleeping.

Support plans we viewed were up to date and reflected people's individual care needs. For example, one person was identified as being at risk of a pressure ulcer. A Waterlow pressure ulcer risk and prevention tool had been completed, was regularly reviewed and identified the person as being at high risk. Their support plan described the individual needs of the person and action to be taken to reduce the risk of the person developing a pressure ulcer. For example, they had an appropriate bed and mattress in place, staff were to regularly check the person's skin for signs of redness and report any issues, ensure their personal hygiene needs were being attended to, and seek advice of relevant professionals when required. Records were regularly reviewed and up to date.

Another person was identified as being at risk of falls. Their mobility support plan described the person as being independently mobile, however, were at times unsteady on their feet and at high risk when an infection was present. Staff were directed to be observant of the person when they were mobilising around the home and look out for signs of increased unsteadiness, pain, discomfort and tiredness. The person's support plan and falls risk assessment were regularly reviewed and up to date.

Daily records were maintained for each person and included information on their health, support provided, activities carried out, sleep pattern and medicines.

The service provided a variety of activities for people who lived at the home. The weekly activities planner included reminiscence sessions, days out, board games and jigsaws, card games, sing-alongs, bowls, film afternoons, one to one therapies, and Sunday worship. For people with dementia, the service had memory boxes that included items to remind people of interests and places to visit. For example, trains and the seaside. We observed staff spending time with people, showing them the contents of the boxes.

The home had its own pub, which we saw was very popular in the afternoon. People enjoyed having a drink and a chat with other residents, and listening and singing along to music. Activities staff we spoke with had a good understanding of people's individual likes and preferences. This meant the provider protected people from social isolation.

The provider's complaints procedure was on display in the home. This provided information on how to make a complaint, who to contact and how long it would take to receive a response to the complaint.

Complaints records included details of action taken, copies of correspondence with the complainant and records of meetings with staff and people involved. All the complaints we saw had been satisfactorily dealt with. People and family members we spoke with were aware of how to make a complaint but did not have any complaints about the service. This showed the provider had an effective complaints policy and procedure in place.

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us there were a couple of communal rooms in the home that they were planning on making changes to so they could be better utilised. The last major project had been the creation of the pub and it had been very successful. The manager also told us that as bedrooms became vacant, they would be refurbished with new carpets and furnishings.

The service had good links with the local community. The home entered the local 'Blooming good fun' garden competition each year and were runners up in 2015 and 2016. The manager told us they made use of a local community centre for bingo, dancing and teas. They also had good links with the local church and one person was supported by staff to attend a local club twice per week.

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

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

Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. They told us, "I love it here", "It's a great place to work" and "I can go home at the end of my shift with my head held high, knowing me and my team have done the best we can."

Staff were regularly consulted and kept up to date with information about the home and the provider. The provider produced a monthly staff newsletter and staff meetings took place regularly, including meetings for each of the different departments and night staff. Results from the staff survey carried out in 2017 were very positive and included comments such as, "Stanley Park is a good place to work", "I have no issues, I'm happy in my role", "I wouldn't change a thing. Stanley Park is a fantastic place to work" and "The atmosphere within our home is fantastic."

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

The provider carried out a 'Quality outcome review' every two months that was based on the CQC five domains. This included a review of safeguarding, medicines, staffing, health and safety, training, nutrition, discussions and feedback from staff and people who used the service, and an action plan was put in place for any identified issues. For example, the review in July 2017 identified that some medicines e-learning training was not up to date and the ground floor treatment room temperature was slightly above the recommended level. These had been actioned or were in the process of being actioned.

The manager had an audit schedule, which included auditing a different area each month. For example, health and safety, infection prevention and control, medicines, documentation, nutrition and choking risk, activities, mental capacity and DoLS, tissue viability, and living well with dementia. Audits we saw were up to date.

A monthly quality assurance and health and safety meeting took place, which included a review of accidents and incidents, complaints, safeguardings, DoLS, internal audits, customer satisfaction, and health and safety.

A monthly residents' and relatives' meeting took place, and family members and visitors were regularly surveyed to gather their thoughts on the quality of the care provided at Stanley Park. Feedback was provided on the 'You said, we did' notice board. For example, someone had commented about the availability of snacks and drinks. In response, the manager had discussions with kitchen staff and a juice machine had been bought.

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