Stoneleigh Residential Care Home Limited

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Inspection report

24 Clarence Road South
Weston Super Mare
Avon
BS23 4BN

Tel: 01934626701
Website: www.stoneleighcarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Stoneleigh Residential care home is a detached Victorian house. There were two lounge areas, an entrance hall, dining area and upstairs offices. There is a front and rear garden. The rear garden has an outdoor seating area with table and chairs. The home accommodates up to 25 people who do not having nursing care needs. At the time of this inspection there were 24 people living at the home.

There was a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 23, 25, 26 May 2016. A breach of legal requirements was found as care records did not contain support plans and risk assessments that identified people's risk relating to skin care and their risk of choking. Personal evacuations plans did not contain details of what support or equipment the person would need in an emergency situation. Medicines were being left for people to take but records confirmed the person had taken them. We also found medicines returned to the pharmacy had not been recorded as returned.

After the comprehensive inspection, we used our enforcements powers and served a Warning Notices on the provider on 5 July 2016. This was a formal notice which confirmed the provider had to meet one legal requirement by 5 October 2016.

We undertook this focussed inspection to check they now met this legal requirement. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stoneleigh Residential Home on our website at www.cqc.org.uk

At this latest inspection we found actions had been taken to improve people's safety however guidelines were not always being followed. Personal evacuations plans did not always contain what equipment people required and medicines records were not always accurate.

One person was found to be at risk of receiving un safe food that was not prepared in line with their support plan. This placed them at risk of choking and was not in line with a recent speech and language therapist advice.

People's care plans did not always hold relevant guidelines that would enable staff to provide care safely. Staff confirmed they accessed people's care plans to follow guidelines about the assistance people required when mobilising.

People's personal evacuation plans required updating to reflect the individual support and equipment people needed should they require assistance in an emergency.

People did not always receive their medicines safely as medicines were being left for people but record's confirmed the person had taken them.

The legal requirement had not been met.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

We found action had been taken to improve people's safety however guidelines were not always being followed for one person.

People's care plans did not always contain guidelines for staff to follow relating to people's equipment.

People's medicines were not always safely managed.

People did not have a personal evacuation plan that confirmed what equipment and support they required from staff in the case of an emergency.

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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.

We undertook this unannounced focussed inspection of Stoneleigh Residential Home on 1 November 2016. This inspection was done to check that improvements to meet legal requirements after our comprehensive inspection on 23, 25, 26 May 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service.

The inspection was undertaken by one adult social care inspector. During the inspection we spoke with five people living at Stoneleigh, the manager, the chef, the office administrator and three members of staff. We looked at the care records for five people living in the home.

We also looked at records relevant to the running of the service. This included, staff observations, training records and medication records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service on 23, 25, 26 May 2016 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). Some aspects of the service were not safe. This was because care records did not contain support plans and risk assessments that identified people's risk relating to their skin care and choking risks. Personal evacuations plans did not contain details of what support or equipment the person would need in an emergency situation. Medicines were being left for people to take but records confirmed the person had taken them. We also found medicines returned to the pharmacy had not been recorded as returned.

At this latest inspection we found actions had been taken to improve people's safety however guidelines were not always being followed. Personal evacuations plans did not always contain what equipment people required and medicines records were not always accurate.

One person's care plan had been updated with detailed guidelines for staff to follow relating to modifying their diet. The guidelines stated the person had been advised to have 'mashable foods, crust less bread, no grains or hard foods' by a health professional. The guidelines also confirmed 'If refused please record' as the person was not always following the advice from the health professional. The records showed this person had capacity and was therefore able to decline to follow the advice. However, there was no risk assessment that clearly highlighted to staff the risk to their swallowing during meal times or what actions staff should take should the person cough or choke whilst eating. Their care plan had a support plan in place that confirmed how the persons' diet should be modified to a 'texture E'. During lunch time they highlighted to us that they were unable to eat part of their lunch. They confirmed their frustration at being unable to eat the meat as it was not soft enough for them and said they would choke on it. We raised this with the chef who said they spoke with the person every day to check what they wanted. They told us the person had been happy to have the meat option today and that the person could decide daily. They said they knew the person was on a modified diet and that they should only eat soft foods due to the risk of choking. They told us that the person was declining to have their food modified. The chef spoke with the person after we highlighted the risk to them choking on the meat. They agreed they would now discuss everyday whether there were any parts of the meal which needed to be softer. We did not see records which showed staff had been recording when the modified food was being refused as stated in the person's care plan. There was also no guidelines in place to follow should the person have difficulty when eating non-modified foods. We fed this concern back to the manager so that they can ensure staff are following guidelines.

We found people's personal evacuation plans had not been fully updated to reflect people's individual support and the equipment they needed, should they require assistance in an emergency. We reviewed five evacuation plans and found details of what equipment the person required still missing. For example, there was no information that the person required assistance and equipment to get out of bed or if the person required equipment to mobilize. We spoke with two staff and the manager about what support these people would need. They were able to demonstrate they knew what support the people would require in the event of an emergency. This meant that although staff were able to demonstrate what support and equipment people would require, people could be at risk if there were staff that were unfamiliar with what support the

person required in the event of an emergency.

People did not always receive their medicines safely as medicines were being signed as administered but were being left for people to take. This is not in line with The National Institute for Health and Care Excellence which confirms, 'Where people are
supplied with medicines for taking themselves records must be accurate and reflect their self administration'. We found whilst speaking to people about how staff administered their medicines we found one person had been given their medicines but had one tablet still on their tray. They confirmed they had been feeling unwell that morning and so had left it for later. We reviewed the record for administering this medicines on the Medication Administration Record (MAR)s. The medicines had been signed as administered and taken by the person that morning. The manager confirmed they had administered the medicines to the person and observed the person take the tablet. They confirmed they had just checked the person due to them feeling unwell and a tablet was on the side. They told us, "They must have spat it out". This meant the record did not accurately reflect that the person had not taken one of their tablets. One person we spoke with confirmed how staff leave their medicines. They told us, "I don't need watching over, they leave my medicines on a breakfast tray". They were unable to explain any more about this practice apart from that staff trusted them.

Two staff confirmed they administer one person's medicine and sign to say they have taken it. They said they leave the medicine for the person to take and then go back and collect the empty container later in the day. Both staff said that when they leave the person their medicines they sign to say they have taken the medicines when in fact they have not actually taken it. We fed this back to the manager as medicines should not be signed as taken before the person has taken them as the person might decide not to take them but the record confirms that they have. The manager confirmed they would liaise with the Pharmacy team who were due to visit in the next week regarding the signing for medicines not taken.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

The manager confirmed they had started to observe and spot check staff practice whilst staff administered medicines. This was so staff competency could be monitored and any concerns actioned. Staff confirmed they were being observed administering medicines. They told us, "They watched me in my practice before I was signed off" and "I have been observed administering medicines". Supervision records confirmed this observed practice. Staff who administered medicines wore an apron. This allowed people and staff to know that the staff member was busy administering medicines. Medicines that had been returned to the pharmacy were accurately recorded as returned. This is important as it gives a clear audit trail of medicines no longer retained by the home.

People who required support and assistance from staff did not always have specific guidelines in their care plans for staff to follow. The manager confirmed each person had a moving and handling risk assessment in the persons room for staff to follow. This confirmed what equipment and support the person required, including what sling and hoop should be used. We found the detail of these risk assessments were not always reflected within people's care plans. For example, we found three care plans did not contain guidelines on what loop staff should use on the person's sling. This is important as two staff confirmed if they were unfamiliar with how to support people they would review the person's care plan to find the guidelines on how to support the person. We asked them how they would support one person with their mobility and what sling hook they would use. Both staff confirmed they would review the persons care plan for this information. We found this information was not available within the persons care plan and was only available on the risk assessment in the person's room. This meant people's care plans did not always hold

relevant guidelines that would enable staff to provide care safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care.