Coverage Care Services Limited

Stone House

Inspection report

Union Street
Bishops Castle
Shropshire
SY9 5AJ

Date of inspection visit:
29 May 2019

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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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service: Stone House is a residential care home which provides support with personal care needs for up to 40 people, some of who may be living with dementia. At the time of this inspection 33 were living at the home.

People's experience of using this service:
People and their relatives told us they were supported by an exceptionally caring and considerate staff team who knew them well, treated them as individuals and with the upmost respect. A person who lived at the home said, "I can't speak highly enough about the staff. They really are amazing, and they put themselves out for me." A relative told us, "They [staff] should have a gold standard award. They are all so kind and caring and will do anything for [relative]. I wouldn't want my [relative to be anywhere else. You couldn't get better than this." Staff went out of their way to respect people as individuals and provided exceptionally compassionate care to all. Staff had developed meaningful caring relationships with people and were committed to ensuring people lived fulfilling lives and were protected from social isolation.

People felt safe and could raise concerns. The staff team knew the action to take to safeguard people from the risk of harm and abuse. They supported people to take managed risks and enabled them to live the lifestyle of their choosing. Staff were recruited safely and deployed in sufficient numbers to meet people's needs. People received their medicines when they needed them from staff who were trained and competent to carry out the task.

People's health and nutritional needs were monitored and met. People saw health care professionals when required. People were provided with a nutritious and healthy diet, whilst still ensuring there were treats and snacks in-between meals.

Staff understood the importance of ensuring people's rights were understood and protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The registered manager led by example. People, staff and relatives felt their views were important and that their opinions were listened to. Staff were valued by the provider and registered manager. Staff morale was good, and staff were encouraged to share ideas and suggestions for improvements. There was an emphasis of continuous learning and there were effective procedures in place to monitor and improve the quality of the service provided.

Rating at last inspection: At our last inspection in September 2016 (report published 11 November 2016) the service was rated good.

Why we inspected: This was a scheduled inspection based on the previous rating.

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Stone House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by one adult social care inspector.

Service and service type:
Stone House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This was an unannounced inspection.

What we did:
The provider submitted a provider information return (PIR) prior to this inspection. 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 also reviewed information we held about the service such as previous inspection reports and statutory notifications. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority, commissioners and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. No concerns were raised by the professionals we contacted.

During the inspection we spoke with 11 people who lived at the home and three relatives. 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 could not talk with us. The registered manager was available throughout our inspection. We also spoke with five members of staff and met with a member of the provider's senior management team. We looked at three people's care plans, medication records, staff training records and records relating to health and safety and the management of the home.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
•People told us they felt safe living at the home and with the staff who supported them. One person said, "I couldn't feel safer than I do here." A relative told us, "I have no concerns about my [relative's] safety when I am not here."
•Staff knew how to protect people from the risk of harm or abuse.
•Staff had received training and knew how to recognise and report any concerns. A member of staff said, "I would report it straight away if I thought residents were being abused."
•The registered manager had reported concerns to the local authority safeguarding when concerns had been raised and they worked in partnership with them to ensure people were safe.

Staffing and recruitment
•People were protected from the risk of harm or abuse because the provider followed safe staff recruitment procedures and made sure staff were suitable to work with people before they started working at the home.
•People were supported by sufficient numbers of staff who were able to meet their needs and help keep them safe.
•Staffing levels were kept under review and adjusted to meet the numbers and changing needs of the people who lived at the home.

Assessing risk, safety monitoring and management
•Risks to people were assessed and care plans had been developed to manage risks. These included risks associated with eating and drinking, falls and risks associated with pressure damage to the skin.
•Risks associated with the management of behaviours which may challenge were assessed and care plans were developed to manage behaviours in the least restrictive way.
•Regular checks were carried out to make sure the environment and equipment remained safe. Repairs had been completed where needed.
•There were risk assessments in place relating to health and safety and fire safety.
•Staff knew the action to take in the event of an emergency. Each person had an emergency evacuation plan. These gave details about how to evacuate each person with minimal risks to people and staff.

Using medicines safely
•Medicines were managed and administered by staff who were trained and assessed as competent to carry out the task.
•People received their medicines when they needed them. A person who lived at the home said, "The staff bring me my medicines at night. I can speak up about my tablets and if I need pain killers, I just ask."
•There were clear protocols in place for the use of 'as required' medicines which helped to ensure staff

followed a consistent approach.
•People's medicines were reviewed annually by their GP to ensure they remained effective and appropriate.

Preventing and controlling infection
•People were protected from the risks associated with the spread of infection because staff understood and followed the provider's procedures.
•Staff had access to good supplies of personal protective equipment (PPE) and we observed staff using these appropriately.

Learning lessons when things go wrong
•The registered manager maintained a record of any accidents or incidents. These were entered onto a computer system and reviewed and monitored by the provider's senior management team. This helped to identify any trends.
•Where things went wrong, the management team were keen to explore the reasons and to take steps to reduce the risk of it happening again. For example, following an incident staffing levels were increased.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•People were assessed before a placement at the home was offered. This helped to ensure that the home could meet people's needs, preferences and aspirations.
•A person who lived at the home said, "I was visited in hospital and I was asked about the help I needed. I was also asked about my interests and my likes and dislikes. My [relative] came and looked around the home before I moved in. Everything has been as promised and I haven't been disappointed."
•Assessments of people's diverse needs such as religion were discussed prior to admission.
•Assessments were used to formulate a plan of care. This provided staff with the information they needed to meet the person's needs and preferences.
•Staff had a good knowledge of people's needs and preferences and provided care in a way that met their individual needs. A person who lived at the home said, "They [staff] have got to know me very well."
•Staff had received training about how to support people living with dementia and followed best practice guidance. This helped to create a happy relaxed environment for people.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
•People saw doctors and other professionals to meet their specific needs when they needed. These included GP's, dentists, opticians, speech and language therapists and specialist health care professionals such as mental health practitioners.
•People's health and well-being was monitored and understood by staff. Care records showed that advice was sought from health care professionals as soon as concerns about a person's health were identified.
•One person told us, "I was rubbing my eye one day and [name of staff member] said, 'is your eye sore again? We need to get you so more eye drops from the doctor.' By the next day, I had the eye drops and it cleared up really quickly."

Supporting people to eat and drink enough to maintain a balanced diet
•People's nutritional needs were assessed and kept under review. Care plans contained information about people's needs and preferences.
•Where risks were identified, care plans were in place to manage and mitigate risks to people. For example, one person had been assessed as being at high risk of choking. A care plan had been developed in accordance with the advice of a speech and language therapist and staff had a good knowledge about the consistency that food should be prepared.
•People were offered a selection of snacks and drinks throughout the day. A fresh fruit platter had been

introduced to ensure people received healthy options. Ice lollies were available to help people keep hydrated during hot weather.
•Hydration mugs were used to prompt a person to drink and to alert staff that a person may require encouragement to drink. Hydration mugs used a sensor to detect when the mug was lifted. An audio prompt and colour changing base alerted staff that the person has not picked up the mug within specified time frames. We observed a member of staff responding to this during our visit and encouraging a person to have a drink.

Staff support: induction, training, skills and experience
•People were supported by staff who had the training and skills to meet their needs. A member of staff said, "There is lots of training here. I feel I have had the right training to meet the needs of our residents."
•Members of the management team and staff have completed specialised training in caring for people who were living with dementia.
•New staff completed an induction and training programme which gave them the basic skills and training they needed. A member of staff told us, "I enjoyed my induction and training. I was able to shadow experienced staff which was really good as I was able to get to know the residents."

Adapting service, design, decoration to meet people's needs
People lived in a home which was well-maintained and met their needs.
•Since the last inspection the number of units had reduced from five to three. This meant people lived in a more spacious environment.
•The unit for people who were living with dementia had been redecorated in accordance with best practice and guidance. The environment helped to provide a relaxed and calming place for people to live.
•People had been involved in choosing photographs of local landscapes which had been placed in corridors and gave the illusion of looking out through a window.
•People had also chosen the colour of their bedroom doors which had been designed to replicate a front door.
•There were adequate communal spaces to enable people to socialise or spend time quietly.
•Accommodation was arranged over two floors and there was a passenger lift to enable people to access all areas.
•People had their own bedrooms which they had personalised in accordance with their tastes and preferences.
•There were pleasant and accessible courtyards in the centre of the ground floor units.

Ensuring consent to care and treatment in line with law and guidance
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 make 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on

people's liberty had been authorised and whether any conditions on such authorisations were being met.

•Staff had received training about the MCA and knew how to support people in a way that respected their rights.
•We observed staff asking for people's consent before assisting them. We heard staff asking people how and where they wanted to spend their time.
•Where people lacked the capacity to consent to specific areas of their care, best interests' decisions were made and recorded. An example included the covert administration of medication.
•The provider had made appropriate applications to deprive people of their liberty where people required this level of protection to keep them safe.

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service

Ensuring people are well treated and supported; respecting equality and diversity
•People and their relatives were exceptionally positive about the staff team and of the care and support they received. One person said, "I can't speak highly enough about the staff. They really are amazing, and they put themselves out for me. One member of staff who left knitted me a special blanket and gave me a hug and came back to visit me." They also said, "The kitchen staff made me a cake for my birthday and I had a present. You get gifts at Easter and Christmas too. How wonderful is that?"
•A relative told us, "They [staff] should have a gold standard award. They are all so kind and caring and will do anything for [relative]. I wouldn't want my [relative to be anywhere else. You couldn't get better than this."
•There was a relaxed, calm and happy environment which benefitted the people who lived at the home.
•Staff looked happy and they were committed to ensuring people felt valued. Two members of staff had relatives living at the home. One member of staff said, "I wouldn't want my [relative] to be cared for anywhere else. They get the best care here. I think it says it all if you are happy to have a relative here."
•We observed many acts of genuine kindness. For example, staff were not task led and their focus was on the people they supported. When one person became distressed, a member of staff comforted them and got their special soft toy. They linked arms with the person and walked with them. This resulted in the person becoming more relaxed and engaged with the member of staff.
•We heard about how a staff member noticed when a person became distressed when they saw their reflection in a mirror. The member of staff purchased, with their own money, an opaque film which was placed over the mirror. This had a positive impact and the person no longer became distressed. With this knowledge, blinds were fitted over mirrors in communal bathrooms which could be lowered when the person used the bathroom.
•Care plans contained profiles of people and recorded key professionals and relatives involved in their care. Care plans detailed family and friends who were important to them and provided information about people's social history, hobbies and interests. This helped staff to be knowledgeable about people's preferences and family dynamics and enabled them to be involved as they wished.
•People's protected characteristics such as religious preferences were discussed and recorded in their plan of care. People were able to take part in religious ceremonies in the home.
•There were booklets available from Churches in the surrounding areas which meant people could keep up to date with news and events in the area where they used to live.

Supporting people to express their views and be involved in making decisions about their care

•Staff were exceptional at supporting people to have a voice and used various methods to help people who found it difficult to express their needs and preferences. These included objects of reference, pictures and easy to read information.
•Staff were extremely patient when they communicated with people, ensuring people were given time and reassurance when making a decision. Staff ensured they were at eye level with the person and used gentle touch to reassure them.
•Staff respected people's right to change their mind. For example, we observed a member of staff supporting a person to a lounge area. The person wanted to sit in several different chairs and was assisted to do so. When the person became anxious, the staff member asked the person where they would like to go, offered them choices and walked with them to the dining room where they relaxed and enjoyed a drink.
•Where appropriate and with the person's consent, people's relatives were consulted about their support and care. Information about advocacy services was readily available and promoted.
•There was clear signage which enabled people to orientate themselves around the home. On the unit for people living with dementia, toilet doors had been painted yellow and walls painted a darker colour to contrast the white fittings to make them more accessible to people.

Respecting and promoting people's privacy, dignity and independence
•We observed staff interactions with people to be exceptionally kind and respectful.
•The registered manager and staff team had gone above and beyond to raise a substantial amount of money to improve and enhance the unit for people who were living with dementia.
•This had resulted in a positive impact for people which included a calmer and meaningful environment and a reduction in anxiety in some people.
•Staff took time to assist people to look smart and well groomed. For example, a person who was living with dementia looked very happy when they left their room looking very smart and wearing makeup and jewellery. A member of staff said, "[Name of person] loves to dress nicely and have their makeup on."
•Staff responded quickly to any requests for assistance and they helped with personal care needs in a discreet manner.
•We observed, and people told us they were able to spend time in the privacy of their bedroom when they wanted. One person said, "I can come to my room whenever I want. The staff are always reminding me that this is my home and I can do what I want."
•Staff knocked on bedroom doors and waited to be invited in.
•Staff ensured that mobility aids were within easy reach of the people who required them. Staff also ensured that people had their hearing aids and spectacles where appropriate and that these were clean and in good order.
•People's care records were securely stored, and we observed that staff ensured they did not discuss people in front of others.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Care planning and delivery was person-centred. Person-centred planning is a way of helping someone to plan their life and support they needed, focusing on what was important to the person.
•Care plans detailed information which was important to the person such as interests, daily routines and family members.
•Staff knew about people's preferences and what was important to them. They spoke with great fondness about the people who lived at the home and engaged in conversations about their family and interests.
•We observed people chose what they did and where they spent their time. A person who lived at the home said, "This really feels like my home and I can do as I please."
•People and, where appropriate their relative were involved in regularly reviewing the care they received to ensure care plans reflected people's needs and preferences.
•People benefited from strong links with the local community. Local groups regularly held their meetings at the home. We heard about one person who enjoyed attending a group which they used to run before they moved to the home.
•People from the local community and people who lived at the home enjoyed regular 'knit and natter' sessions and exercise sessions.
•Local volunteers regularly visited the home and provided a library service and offered to shop for any items people required.
•Since our last inspection the provision of activity staff and opportunities for people had increased. There were daily activities, social events and trips out.

Improving care quality in response to complaints or concerns
•The provider had systems in place to record, investigate and to respond to any complaints raised with them.
•People and their relatives felt able to raise any concerns when needed. A person who lived at the home said, "I don't have any worries. I would speak to [name of registered manager] if I needed to." A relative told us, "I have raised little niggles in the past and they have been sorted."

End of life care and support
•Nobody using the service was receiving end of life care. However, care plans showed that there had been discussions with people and their relatives about their preferences during their final days and following death.
•People's religious preferences were recorded in their plan of care.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•The service had a manager registered with the Care Quality Commission. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

•The registered manager operated an open-door policy and they were well known by the people who lived at the home, staff and visitors.

•There was a clear staffing structure in place and the staff we spoke with were clear about their role and responsibilities.

•There were effective systems to monitor staff skills, knowledge and competence.

•Staff were able to discuss their role through regular supervisions and annual appraisals.

•Staff were aware of the whistleblowing procedure and said they would use this if the need arose.

•In accordance with their legal responsibilities, the registered manager had informed us about significant events which occurred at the home within required timescales.

•The ratings of our previous inspection had been clearly displayed in the home and on the provider's website.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•The registered manager was passionate about providing people with a high standard of care and their ethos had been embraced and adopted by the staff team.

•People were supported by a staff team who felt valued and motivated to do their work. Staff morale was good. A member of staff said, "It's all about making our residents have a really happy life here and we all chip in to make that happen. It's a lovely home."

•The registered manager had informed professionals such as the local authority safeguarding team when concerns had been raised. They had also informed people's relatives where there had been concerns about people's care or well-being. This was in accordance with the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•People's views were valued and responded to. Throughout our visit we observed staff seeking people's views about what they wanted to do, what they wanted to eat and who they wanted to support them.

•There were regular meetings for people, their relatives and staff where views were encouraged. Suggestions for change were considered and responded to. For example, changes were made to activities and menus based on the views of the people who lived at the home and their relatives.

•When staff discussed a lack of contact with the provider's senior management team, arrangements were made for them to regularly visit the home and attend staff meetings.

•Annual surveys were sent to the people who lived at the home, their relatives and staff to seek their views on the quality of the service provided. The results of a recent survey had been positive. Surveys had also been produced in an easy read format.

•People were involved in regular reviews of the care they received with their relatives, professionals and staff that knew them well.

Continuous learning and improving care

•The were effective procedures in place to monitor and improve the quality and safety of the service provided.

•Regular audits and checks were carried out by the registered manager. Findings were reviewed and action was taken to address any shortfalls. Quality visits were also carried out by the provider's senior management team.

•Memory boxes were being created to help people who were living with dementia to orientate themselves to their bedroom. Boxes would be filled with items and photographs which were personal and meaningful to each person and would be placed outside of the person's bedroom.

•There was a culture of continuous learning. The registered manager kept themselves up to date with developments and best practice in health and social care to ensure people received positive outcomes. They attended regular management meetings where learning and best practice were shared and received updates and newsletters from professional organisations.

•The provider's management team had discussions and talks from lesbian, gay, bi-sexual and transgender (LGBT) groups and as a result, changes had been made to care planning documentation to ensure people's protected characteristics were fully considered.

Working in partnership with others

•The service worked in partnership with health and social care professionals to achieve good outcomes for the people. These included the local authority safeguarding team, GP's, and specialist health professionals.