Stilecroft (MPS) Limited

Stilecroft Residential Home

Inspection report

51 Stainburn Road
Stainburn
Workington
Cumbria
CA14 1SS

Tel: 01900603776

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06 October 2022
13 October 2022

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03 November 2022

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Stilecroft Residential Home is a residential care home providing personal care to up to 44 people. The service provides support to older people and people living with dementia and mental health needs. At the time of our inspection there were 38 people using the service.

Stilecroft Residential Home accommodates people in one adapted building across three floors.

People's experience of using this service and what we found
This was a targeted inspection that covered safeguarding people from abuse, assessing and managing risks and eating and drinking. Based on our inspection we identified checks of people and health and safety were not always recorded to show they had taken place. This included checks of equipment people used, such as sensor mats. People were aware of people who may be at risk, including at risk of weight loss. We identified improvements were needed to risk assessment records and made a recommendation about this.

Recording systems did not always show when people had been referred for additional support with weight loss and what advice had been given. The registered manager was responsive to our feedback and made changes following this. These changes had yet to be embedded.

People received appropriate support from staff to encourage them to have regular drinks and assist them with meals. People responded positively to staff.

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

Rating at last inspection
The last rating for this service was requires improvement (published 16 June 2022).

Why we inspected
The inspection was prompted in part due to concerns received about people's eating, drinking and weight loss. A decision was made for us to inspect and examine those risks. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of eating, drinking and weight loss. This inspection examined those risks.

We use targeted inspections to follow up on Warning Notices or as in this instance, to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. We found no evidence during this inspection that people were at risk of

further harm from these current concerns.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated.	**Inspected but not rated**
Is the service effective? Inspected but not rated.	**Inspected but not rated**

Stilecroft Residential Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider was meeting requirements for ensuring people had enough to eat and drink and risks linked to people, including weight loss were managed. We will assess all of the key questions at the next comprehensive inspection of the service.

Inspection team
The inspection was undertaken by 2 inspectors.

Service and service type
Stilecroft Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stilecroft Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 06 October and ended on 14 October 2022. We visited the location on 06 October. We reviewed people's care records remotely on 11 and 13 October 2022. We spoke with the registered manager and nominated individual on 14 October 2022 to provide feedback. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service. We spoke with 3 members of staff including the registered manager and 2 senior care workers. We carried out observations throughout the service, including observing the people's dining experiences during lunchtime.

We reviewed a range of records. This included 7 people's care plans in part. A variety of records relating to the management of the service, including quality assurance checks and health and safety check records were also reviewed.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check specific concerns we had about the service. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

- Health and safety checks had not always been carried out or recorded to ensure all areas at the service were safe and maintained. For example, fire alarm tests had not been carried out for over 1 month, the provider's records stated this should be checked weekly. The registered manager advised they would take steps to prevent these checks being missed in the future.
- Although staff were knowledgeable about risks to people and how to manage these, records including nutritional risk assessments did not always clearly identify actions being taken to support people. The registered manager advised improvements would be made to risk assessment records.
- Checks identified in people's care plans to keep them safe and ensure equipment was working were not always recorded to show these were taking place.
- The registered manager monitored people identified as being at risk of losing weight to ensure appropriate support was in place to reduce this risk to people.
- A robust system was in place to review and analyse where people had experienced falls to help lessen risks and inform learning across the service.

We recommend the provider reviews and follows best practice where risks are identified linked to people's nutrition.

Systems and processes to safeguard people from the risk of abuse

- Staff understood their safeguarding responsibilities; staff knew how to identify and raise any concerns appropriately to protect people from the risk of abuse.
- People felt safe with staff and responded positively to interactions with them.
- The provider's safeguarding log was not always up to date or complete to ensure safeguarding concerns were logged and followed up in-line with the provider's processes.

Inspected but not rated

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.

At our last inspection we rated this key question requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check specific concerns we had about the service. We will assess the whole key question at the next comprehensive inspection of the service.

Supporting people to eat and drink enough to maintain a balanced diet

- When staff had identified concerns about people's nutrition and weight loss, records did not always clearly identify when referrals had been made to professionals or what advice had been given. This meant we could not be fully assured concerns were escalated and advice acted on in a timely way. Following our feedback, the registered manager had started to introduce new ways of recording this information.
- Staff worked together to encourage people to keep hydrated. One senior care worker said, "I monitor it every shift. I spend quite a lot of my day chasing it and making sure people are getting drinks."
- People received proactive support from staff at mealtimes to assist them with eating and drinking. People were encouraged to be as independent as possible with this. One care worker supported a person to drink from their beaker, they said, "Come on, you and me can do this together."
- People enjoyed their meals and mealtime experiences. One person told us, "I've come in 10st and I'll go out 12st."
- People with specialist dietary requirements received appropriate support.