Flarepath Limited

Stepping Stones

Inspection report

Church Road
New Romney
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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service
Stepping Stones is a residential care home providing personal care to three adults with a learning disability, mental health condition or autistic people at the time of the inspection. The home can support up to four people and was provided in a newly built house. One person had moved out of the home since our last inspection on 7 May 2021. The provider was not able to move anyone new into the home as we had imposed a condition on their registration to restrict any new admissions to the home.

The home was established for short- or medium-term accommodation to assess and provide specialist support for people living with a learning disability or autism. The aim is for people to develop their skills and independence to move onto other appropriate long-term accommodation.

People's experience of using this service and what we found
People had been harmed and remained at risk of further harm. Incidents of psychological and physical abuse between people were not always reported to the local safeguarding authority and the Care Quality Commission.

Incidents were not reviewed by the registered manager or provider to ensure action was taken to learn from these and prevent them reoccurring. Care plans and risk assessments were not updated following incidents. Action was not taken to ensure people's safety.

Staff did not have the skills, knowledge and guidance to support people during incidents of behaviour that challenged. This resulted in people's anxieties and behaviour escalating and put people and staff at risk of harm.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This was a targeted inspection that considered risk management and safeguarding under our key question of Safe. Based on our inspection of these areas the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• The model of care and setting had not maximised people's choice, control and Independence.
Right care:
• Care was not person-centred and did not promote people's dignity, privacy and human

Rights. Staff lacked understanding of how to support behaviour that challenged in a positive way.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people led confident, inclusive and empowered lives. The lack of understanding by the provider, registered manager and the resulting attitude and values displayed by staff had led to a negative culture in the home. This had a negative impact on people's self-esteem, confidence, human rights and quality of life.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 17 June 2021) and there were multiple breaches of regulations. We imposed conditions on the location which meant the provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to check on a specific concern we had about risk management following incidents. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific 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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and safeguarding people from abuse and improper treatment at this inspection.

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

Follow up
Following this inspection, we worked closely with commissioning authorities to ensure people were safeguarded from on-going harm. Three people were supported to move out of Stepping Stones. There is currently no one living at Stepping Stones.

Special Measures
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Stepping Stones

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on specific concerns we had about the management of risk following incidents.

Inspection team
The inspection was conducted by one inspector.

Service and service type
Stepping Stones is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We sought feedback from the local authority who work with the home. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who lived in the home about their experience of the care provided. The other two people living in the home were out for the majority of our inspection. We spoke with five members of staff including the director, deputy managers, team leader and support worker.

We reviewed a range of records. This included three people's care records and incident records. A variety of records relating to the management of the home, including people's daily records were reviewed.

After the inspection
We reviewed incident records and spoke with the director and service commissioners about our concerns.

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 the last inspection this key question was rated as Inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about the providers risk management following incidents.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

- The provider had not alerted the local safeguarding authority of all incidents of alleged abuse as required by law. The provider had continued to not inform the Care Quality Commission (CQC) of incidents of physical and psychological abuse between people. This meant CQC could not be sure all the necessary action had been taken to prevent future incidents of abuse occurring. For example, an incident which occurred on 12 June 2021 where one person threw objects at another person was reported to the local safeguarding authority. However, the provider had failed to report further incidents of the same nature between the same people on the 14 and 15 June 2021.
- People had been harmed and were at risk of further harm. Incident records showed that the provider had continued to not follow their own policies on safeguarding. Following incidents, the provider failed to effectively investigate, review, and identify action to take to prevent future reoccurrence.

Systems were either not in place or robust enough to demonstrate safeguarding people was effectively managed. This placed people at risk of further harm. The provider had failed to protect people from abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to assess and mitigate the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Staff did not have the guidance and skills to manage incidents of behaviour that challenged others. The risks of harm to other people and staff were therefore not managed and escalated. The provider had implemented a 'no restraint' policy since our last inspection but had failed to identify how they would manage these incidents in peoples care records. Staff had still not received up to date training in positive behaviour support by an accredited organisation. There had been incidents where staff had been unable to de-escalate people's anxiety and resulting behaviour. As a result, staff had failed to protect one person from unnecessary harm.
● Staff did not know how to manage incidents of physical aggression. The risks of harm to other people and staff were therefore not managed and escalated. One incident report suggested (that despite a 'no restraint policy'), staff used 'reasonable force'. Yet there were no details of what was meant by 'reasonable force' or review of risk assessments and behaviour support plans as a result. We asked the deputy manager what was meant in another report by, 'remove one person from the patio' and 'took one person to the garden area'. The deputy manager said, "That would have been done verbally" but they did not witness this. We spoke with a team leader who told us, "Since the previous inspection, a no restraint policy was put in place and we can't do anything so just have to let service users damage property and call the police". We asked how they managed incidents of physical aggression between people and their response was, "To get between them, so they are hit rather than people".
● The provider had failed to ensure that following incidents debriefs were completed with staff and incidents were reviewed for learning. Therefore, no action was taken to mitigate the risk of serious incidents reoccurring. People and staff remained at serious risk of harm. For example, an incident on 18 June 2021 involved one person entering the neighbouring homes garden. They threw many heavy and dangerous objects around the garden, at staff and smashed the conservatory window (where people from this neighbouring home spend most of their time during the day). Despite this incident, during our inspection the garden gate between the two homes remained open, allowing people to wander freely between the two gardens. The gardens still contained heavy or dangerous objects which could be thrown such as a cast iron garden chair, heavy plant pots and a large pane of glass.
● Other risks to people were not mitigated which left people at risk of serious harm. For example, one person was at risk from self-harm. An incident had occurred on 12 June 2021 where this person looked for and found objects in the garden to use for self-harm. The provider had failed to take appropriate action to review the person's risk assessment and the incident, to learn and mitigate the risks to prevent a reoccurrence. There remained objects in the garden and house which could be used to self-harm. These included a large pane of glass down the side of the house and a pair of sharp scissors in an unlockable kitchen drawer.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. The provider had failed to assess and mitigate the risks relating to the health safety and welfare of people This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(1)(2)(b)(c)(d).

The enforcement action we took:

Urgent cancellation of providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or robust enough to demonstrate safeguarding people was effectively managed. This placed people at risk of further harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 13(1)(2)(3)

The enforcement action we took:

Urgent cancellation of providers registration