Godfrey Barnes Care Station Limited

Station House

Inspection report

93 Station Road
Rolleston-on-dove
Burton-on-trent
DE13 9AB

Date of inspection visit:
23 November 2021

Date of publication:
16 February 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Station House is a residential care home providing personal care to people living with autism or a learning disability. The service can support up to six people and six people were living there at the time of inspection.

People's experience of using this service and what we found
People were not consistently supported by safely recruited staff who had adequate training. People with diabetes were not always supported in a safe way to receive their medicines. People were supported by staff who were knowledgeable about the different types of abuse but were not always clear on how to report any concerns to the local authority. Quality assurance tools were not always in place or used effectively to ensure improvements were identified and action was taken to improve people's experience of care.

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.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture as there were not always sufficient staff to support people flexibly with their care.

People were supported by staff that wore personal protective equipment such as masks, gloves and aprons in line with government guidance to reduce the risk of transmission. People were supported to have regular visitors within the home. People appeared comfortable with the staff and relatives told us staff were caring. People had comprehensive care plans and risk assessments in place to support staff to meet their needs. Relatives felt able to communicate with the new manager and felt action would be taken in relation to any concerns raised.

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

Rating at last inspection
The last rating for this service was good (published 04 June 2021).

Why we inspected
We received concerns in relation to people's safe care and treatment, staffing and oversight at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Station House on our website at www.cqc.org.uk.

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 breaches in relation to people's safe care and treatment, staffing, recruitment and the leadership of the service.

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

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

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Station 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. 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector.

Service and service type
Station Road 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 however they were in the process of deregistering. At the time of our inspection there was a new manager at the service who planned to put in an application to be the registered manager.

Notice of inspection
This inspection was unannounced.

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. 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.

During the inspection
We attempted to speak with people using the service however they did not wish to speak with us. We therefore spent time observing people in communal areas and staff's interaction with people. We also spoke with four relatives about their experience of the care provided. We spoke with seven members of staff including the manager, operations manager, team leaders and support workers. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the manager to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who visit the service.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
● The provider had failed to ensure staff working with criminal records had a risk assessment in place to ensure they were safe to work with people at the service.
● Staff were not always recruited safely in line with the provider's policies. For example, one staff file did not contain any proof of the staff's identity.
● Staff files contained gaps in staff's employment history and we saw one staff reference from a company not listed as a previous employer on a staff application form.

Systems were not in place to ensure staff were consistently recruited safely. This placed people at risk of harm. This as a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team were responsive to our concerns around staffing and begun making improvements following our inspection to ensure people were supported by safely recruited staff.

● There were not always sufficient staff to meet people's one to one needs in a flexible way and to enable them to access their local community. For example, when there were only four staff on duty this would not enable people requiring higher levels of one to one support at the service to access the community should more than one person wish to at a time. Records showed there were only three or four staff on duty on twelve occasions in November 2021.
● Feedback we received about staffing was consistently reflective of the need for more staff. One staff member told us, "There is a lot to do if there is only four of you. That means people can't go out if they wanted to."
● Relatives gave positive feedback about the current staff group but told us there had been frequent changes to the staff group. One relative told us, "[Staff] are absolutely committed, they care passionately about the people that are there." Whilst another relative told us, "The staff are being changed all the while. You know as well as I do they can't all understand what [our relative] wants from the start but the others that have been there know her. [Our relative's] lost with the new [staff] as far as I can see."

Systems were not in place to ensure there were sufficient staff to support people in a flexible way in line with their needs and wishes. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure all staff had sufficient training to meet peoples' needs. For example, four

staff had not completed their diabetes training despite supporting two people at the service with diabetes. Whilst staff we spoke with told us how to support people with their diabetes needs we found concerns with how people were supported with the diabetes medicines.
● The provider had failed to ensure all staff had completed basic training in moving and handling despite supporting people when mobilising. This placed people at risk of not receiving care in line with best practice guidelines for their mobility needs.
● The provider had failed to ensure all staff who were supporting people who may require restraint in times of distress were trained to do so safely. This had been identified within a recent safeguarding concern by the Local Authority.
● The management team had identified prior to our inspection that multiple staff training was outstanding and completed an action plan to make improvements. However, insufficient action had taken place to ensure identified outstanding training had been completed at the time of our inspection. This placed people at risk of harm.

Using medicines safely
● During this inspection we found staff were not consistently measuring people's blood sugars prior to administering their insulin. This placed people at risk of harm of receiving medicines they did not require which could have been harmful to their health.
● We found a medicine stored within the medicines fridge that was no longer prescribed. Staff were also not recording open dates on people's medicated creams to ensure these were destroyed when no longer in date.
● Whilst all staff administering medicines had been trained, staff had failed to document all administration of medicines and to highlight missed documentation and take action prior to administering people's next prescribed dose. This placed risk of harm of not receiving their medicines as prescribed.

Assessing risk, safety monitoring and management
● During the inspection we found an area of the service which was not safe. It contained an open box of screws and was cluttered with items no longer used within the home. This area was used by a person at the service when they became upset to support them to relax, they accessed this area alone. Staff had not identified this area was unsafe. This placed the person at risk of harm.

We found no evidence that people had been harmed however, 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.

● People had care plans and risk assessments in place which were comprehensive and reflected their needs. This gave staff clear guidance to follow.

Systems and processes to safeguard people from the risk of abuse
● Not all staff had completed safeguarding training and were aware of local safeguarding procedures. This placed people at risk of potential safeguarding concerns not being reported to the Local Authority safeguarding team. Despite this, staff we spoke with were knowledgeable about the different types of abuse and we saw where concerns had been raised with the management team these had been investigated to reduce the risk of recurrence.
● Relatives told us people felt safe and they were confident the management team would take any concerns seriously. One relative told us, "I have raised concerns with [the management team] and I am comfortable [they] would act on them."

Learning lessons when things go wrong

● Staff recorded accidents and incidents and documentation reflected at times action had been taken to reduce future risk to people. For example, following a person exiting the home when they were not safe to do so, extra safety measures were taken to keep the service secure. However, this was not consistent, and some accidents and incidents had not been reviewed or actions had not been taken. There was a new manager at the service who was in the process of reviewing all documentation and ensuring actions were taken to keep people and staff safe. We will check the action they have taken at our next inspection.

Preventing and controlling infection

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was facilitating visits for people living in the home.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- The provider had failed to ensure quality assurance tools were used effectively to drive improvements. For example, a quarterly audit identified improvements were required in relation to recruitment, confidentiality and training. However, no action plan had been completed in relation to this audit to explore how these concerns would be addressed. At this inspection we found continued concerns with staff recruitment and training. This placed people at risk of harm.
- A medicines audit completed two weeks prior to our inspection identified concerns in relation to staff not recording open dates on people's medicated creams. We found this was a continued concern during our inspection and further concerns in relation to medicines had not been identified.
- The provider had failed to identify all areas of improvement required at the service. For example, as discussed in safe, immediate improvements were required to the garage to make this a safe space for people to use. Whilst improvements were made during the inspection this was as a result of us raising concerns as opposed to quality assurance tools highlighting these improvements were required.
- The provider had failed to ensure there was adequate leadership at the service to ensure any improvements required were identified and action was taken. The provider acknowledged that changes in leadership had led to the service requiring improved and consistent oversight and were in the process of registering a new manager at the service.

We found no evidence that people had been harmed however, systems and processes not in place or robust enough to ensure a consistent level of quality care was maintained at the home. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager had commenced at the service very shortly prior to our inspection however had been supporting the service's previous manager for some time. The new manager had begun to identify where improvements were required at the time of our inspection and had completed an action plan. We will check improvements they have made at our next inspection.

Working in partnership with others

- Whilst we saw people had access to healthcare and social care professionals in a timely way, professionals raised concerns about the service. One professional told us, "Our key concerns are around staff not being

trained. Over the past year there has been discussions with past managers then they leave and nothing happens. We have also had lots of issues with communication."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives told us that the changes in management had made communication challenging but that the new manager had made improvements to this. One relative told us, "They have had two or three managers now, we can understand it but it's hard. [The new manager] seems alright at the moment. You can talk to him. We go very often, and we go in and if there is anything, we have a chat."

● We observed people appeared comfortable with staff and the new manager with lots of laughing and joking during our inspection. R relatives also gave positive feedback about staff and the new manager. One relative told us, "The team love the residents…[The] new manager is exceptional, I think he is actually world class."

● The management team worked with us during the inspection to address areas of immediate concern we raised.

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

● People and relatives were asked for their feedback about the service. For example, people completed questionnaires about their care and support and documentation reflected action was taken as a result of these.

● Relatives told us communication had improved at the service and the management team were accessible and responsive to them. One relative told us, "With [the new manager] I could call them, text them, Whatsapp them and within five minutes they have text me back."

● Staff had access to staff meetings and supervisions. One member of staff told us, "It was beneficial, we talked about what I was doing well and what I could do better. It was good."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their responsibilities under the duty of candour and was meeting these.

● The provider was sending notifications to CQC as required.

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 Staff had not completed training in relation to people's needs and fundamental aspects of care such as safeguarding and moving and handling. People will diabetes were not always supported to receive their medicines in a safe way. An area of the service was not safe, whilst improvements were made during the inspection a person had accessed this area alone. This placed them at risk of harm.

The enforcement action we took:

We served a warning notice to the provider advising improvements needed to be made within a set timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance tools were either not in place or used effectively to identify where improvements were required at the service and action taken to ensure improvements are made and sustained. During the inspection we found concerns not identified by the management team and continuing concerns they had previously identified but insufficient action had been taken to address.

The enforcement action we took:

We served a warning notice to the provider advising improvements needed to be made within a set timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always safely recruited in line with the provider's policies.

The enforcement action we took:

We served a warning notice to the provider advising improvements needed to be made within a set timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff to meet people's one to one needs flexible way and to enable people to access the community should they wish to.

The enforcement action we took:

We served a warning notice to the provider advising improvements needed to be made within a set timeframe.