Care Homes UK Ltd

Stockingate Residential Home

Inspection report

61 Stockingate
South Kirby
Pontefract
West Yorkshire
WF9 3QX

Tel: 01977648683

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stockingate Residential Home is a care home providing personal care to 20 people aged 65 and over at the time of the inspection. The service can support up to 25 people.

People's experience of using this service and what we found
Staff were not following current guidance around infection control management for COVID-19 as they were not changing clothing on arrival and departure at the home. Some instances were identified where staff were not wearing their face masks correctly, although all care workers were seen wearing this PPE correctly.

At the last inspection, we made a recommendation around improving the quality of recording relating to people's care and treatment. At this inspection, we found staff knew people's care needs, but care plans were not sufficiently person-centred. Systems of governance had not identified these gaps. Three incidents which were notifiable to us had not been reported.

People were being asked for feedback about the care they received. Staff meetings had not restarted due to the ongoing pandemic, although other systems were used to share key information. Feedback regarding the support from the management team was found to be positive. Staff received ongoing support through training and supervision. People and relatives knew how to complain and were satisfied with action taken where they had raised concerns.

Risks to people had been assessed, although steps to reduce one person's falls risk were not being followed on the day of inspection. Some areas of the home needed maintenance.

Some issues were identified around the recording of medicines management. Staff signed to say they administered all prescribed medicines. However, one person was given their medicines, but they were not observed taking this. Records were not sufficiently detailed for a controlled drug in stock.

People told us they felt safe living at this home and their relatives agreed with this. People, relatives and staff said there were sufficient numbers of staff available to support them. A gap in a staff member's employment history had not been followed up at the recruitment stage, but this had been identified by the provider before our inspection. Other background checks had been completed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We observed natural interactions which were kind natured, between people and staff. Staff took a genuine interest in people's welfare and responded well to people living with dementia. Feedback we received from people and relatives about the staff team was positive. It was evident privacy and dignity was maintained. A

well-delivered programme of activities was taking place in the home.

We have made a recommendation regarding dementia friendly features in the home.

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 requires improvement (published 17 January 2020).

Why we inspected
We received concerns in relation to safeguarding people from abuse. As a result, we undertook a focused inspection to review the key questions of Safe, Caring and Well-led only. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stockingate Residential Home 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 infection control management and having sufficient oversight of the service.

Please see the action we have told the provider to take at the end of this report.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Stockingate 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 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
This inspection was carried out by two inspectors. Following our visit, an Expert by Experience made telephone calls to people's relatives and representations to gather further feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stockingate Residential Home 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 used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We also contacted Healthwatch for their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who lived in the home and nine relatives. We also spoke with the nominated individual, the registered manager and four care workers. 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.

We reviewed a range of records. This included four people's care records in full. We looked at a variety of records relating to the management of the service as well as multiple medication records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 requires improvement. At this inspection this key question has remained the same. 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.

Before our inspection, we received information of concern indicating people were not protected from the risk of abuse. At this inspection, we found safeguarding concerns were dealt with appropriately.

Preventing and controlling infection
• Infection control management required improvement.
• Following our inspection, the registered manager made us aware of a member of staff who worked two shifts whilst only having received a single dose of the COVID-19 vaccine. This was after the recent government deadline for all staff working in care homes needing to be doubly vaccinated. Appropriate action was taken by the provider who reported this issue to us.
• At the time of our inspection, local authority COVID-19 guidance indicated staff should change into a different set of clothes on arrival and departure, to reduce the risk of spreading infection. Staff confirmed they were not doing this. The registered manager said they had received guidance saying this was no longer needed, but we checked this and found staff still needed to follow this requirement. Following our inspection, the registered manager confirmed staff were following this guidance.
• In a small number of instances, staff were seen wearing masks under their chin when they were not in direct contact with people. We discussed this with the registered manager and noted care staff wore PPE correctly.

This was a breach of regulation 12(2)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as government guidance around managing the ongoing pandemic was not being followed.

• The home was found to be clean. There was a sufficient supply of PPE and signs were in places to show areas marked as frequent touch points, meaning they needed more regular cleaning. A safe system for visitors to the home was in place.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives felt they were safeguarded from abuse.
• People consistently told us they felt safe and their relatives also shared this view. One person said, "We wouldn't suffer for any nonsense (abuse)." Relatives commented, "I have never witnessed any raised voices from staff to residents", "[Person] says they feel safe and happy to be living there" and "I have never had to worry about [person's] safety."
• Staff we spoke with were able to describe the signs that could indicate a person was being abused. They told us they would report this to their management team if they witnessed this.

• Safeguarding incidents were recorded in a log which showed the action taken to protect people. However, a safeguarding allegation reported to us by the provider in June 2021 had not been recorded in their log. We discussed this with the registered manager. All other incidents were recorded.

Using medicines safely
• Medicines were not always managed safely and some recording issues were identified.
• One entry in the controlled drugs register did not show who a medicine was prescribed for or the name of the medicine. Following inspection, this was correctly recorded.
• We observed the administration process and saw people received their medicines appropriately. However, on one occasion, the staff member administering left without checking a person had taken their medicines. This person was supervised by a staff member, but the person responsible for administering should be assured the medicines have been taken.
• Medication administration records we looked at showed people's medicines had been signed as administered. Staff received medication training and had their competency checked.

Assessing risk, safety monitoring and management
• Improvements were needed to reduce people's risk of falls.
• One person's mobility care plan described them as needing a clutter free environment as they had experienced recent falls. This person was left unsupervised with a bedside table pushed up against their armchair, which they struggled to remove. This became a trip hazard when they wanted to move from their seat. Another area of the home was identified as having sunken flooring and bathroom flooring was not secure under a door guard. Following our inspection, the provider was consulting with contractors to have these areas repaired.
• We looked at the September 2021 falls analysis which was a monthly analysis on the falls in the home. It was evident that a range of equipment was in place to reduce the level of risk to people.
• Safety certificates relating to the premises were in place. Staff we spoke with understood their fire safety responsibilities and had attended fire drills.

Staffing and recruitment
• There were sufficient numbers of staff on both day and night shifts.
• People, relatives and staff told us there were enough staff to meet people's needs. The registered provider used a dependency tool to calculate the number of staff needed through the day and night.
• Prior to our inspection, there was no use of agency workers. Due to staff vacancies around the time of our inspection, the registered manager occasionally worked shifts to provide the necessary cover.
• We looked at the recruitment of two staff members and saw these files had been audited. A gap in employment for one staff member had not been explored. However, this had been identified through the audit and was being addressed.

Learning lessons when things go wrong
• The registered provider took concerns seriously and looked to learn lessons from these events.
• The provider had taken appropriate action in response to safeguarding concerns which prompted our inspection. The provider created an action plan and was supporting staff closely.

Good

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People were well cared for by a staff team who understood their needs.
• We spoke with one person who told us, "I love it here, I wouldn't want to be anywhere else." Relatives told us, "I haven't seen [person] so happy in a while and I think that it has saved [person's] life living there. The staff love [person] and [person] loves them" and "The staff seem to be a very caring team and have plenty of time to speak to residents."
• We used our short observational framework tool to record observations of interactions between people and staff in one of the communal areas. We saw regular interactions with people when staff entered the room. Staff showed a genuine interest and empathy and made a point of speaking with people at their height if they were sat down. Conversations between people and staff were completely natural.
• We overheard an interaction between a staff member and a person they were supporting with bathing, who was feeling anxious. The staff member reassured the person saying they would make sure the water was a comfortable temperature and checked if the person was okay with the temperature when the water started running. We heard the staff member asking the person, "Can I dry your neck? Is that alright?"

Respecting and promoting people's privacy, dignity and independence
• Staff respected people's privacy and dignity and promoted their independence.
• Two relatives we spoke with said they had concerns about how their family members were dressed when they visited. We shared this feedback with the registered manager after the inspection.
• Staff were able to describe appropriate steps they took to protect people's privacy and dignity. Two people we spoke with confirmed staff knocked on their bedroom door before entering. We saw a staff member looking to enter a shower room who knocked on the door before entering.
• One person had visibly been incontinent. We made the registered manager aware of this who dealt with it in a discreet manner, guiding the person away for a change of clothing. This helped the person to maintain their dignity.

Supporting people to express their views and be involved in making decisions about their care
• We received mixed feedback about relatives involvement in care planning. Relatives indicated they weren't part of reviews, but were given feedback about their family member's welfare if they requested this. The registered manager told us they tried to involve relatives, but attempts to make contact were not always successful.
• One relative told us, "[Person] chooses the times they go to bed. They did contact me for permission to have the COVID-19 vaccination."

• We observed people being given choice around their daily routines. One person was asked what they wanted for breakfast. They said they wanted a crispy bacon sandwich. The staff member asked about sauces and drink preferences. Once the person said what they desired, we saw they were provided with what they asked for.

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 requires improvement. At this inspection this key question has remained the same. 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
• At our last inspection in October 2019, we made a recommendation to the provider to improve the quality of recording relating to people's care and treatment.
• At this inspection, we found care plans still lacked detail in places and this had not been identified in audits. The strategies staff needed to support people effectively were generalised and not sufficiently person-centred.
• The fire risk assessment dated July 2021 identified three actions, of which two were complete. This action was not referenced in the provider refurbishment programme.
• The provider had notified the Care Quality Commission of most events which are reportable to us. However, three safeguarding incidents (February, April and June 2021) involving the same person had not been reported to us.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to assess, monitor and improve the safety of the service were not sufficiently effective.

• Audits were taking place which looked at, for example, staff files, infection control, health and safety and care plans. The registered manager carried out unannounced spot checks in May, June, August, September and October 2021. One of these took place late at night which meant day and night shifts were checked.
• We found some areas of the premises required maintenance. For example, in a ground floor bathroom the flooring was not secured under the door guard which meant there was a potential trip hazard. We also saw flooring was slightly sunken in another area which was a falls risk. The provider had identified this in their refurbishment plan, although no timescales for completion of these works were stated. Following our inspection, timescales for this work were shared with us.

Some people did not have any identifying features on their bedroom doors. We recommend the provider takes steps to make the home more dementia friendly, such as through dementia friendly signage, colour schemes and other features.

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

• We asked for feedback from relatives who told us, "The manager and staff are approachable. There is an open-door policy with the manager" and "From what I have seen, (the home) is well led. They (staff) seem to work as a team. The staff and management are friendly and approachable."
• Staff we spoke with said they were listened to by the management team. One staff member said, "They're approachable. They value us."
• We looked at staff training and found this was mostly up-to-date. The registered manager had identified the need for some staff to have additional support through group sessions to complete outstanding training. Regular supervision support was being provided to staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Since the beginning of the pandemic, staff meetings had not taken place. Staff shared updates through shift handovers and a communication book. People had been individually asked for feedback regarding the menu, laundry, activities and cleaning and this was collectively recorded as a 'resident' meeting in September and October 2021.
• Communication with families during the pandemic was arranged through telephone and video conferencing calls. The activities coordinator used social media to share photos of people engaging in activities with their relatives.
• People were engaged through an activities programme which was organised by an enthusiastic coordinator. One relative commented, "They [people] do have activities. Brilliant activities nearly every day."

Continuous learning and improving care; Working in partnership with others; 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's information return noted that during the pandemic they had been well supported by the falls team, speech and language therapists, occupational therapists, the nurse practitioner and district nurses. They had also worked in partnership with the infection control team and the local clinical commissioning group.
• Relatives knew how to complain and told us when they had used this procedure, they were satisfied with the response they received. One relative told us, "If I did have a complaint, I would speak to the manager."

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 Government guidance around the management of infection control was not being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the service were not sufficiently effective.