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Stanbeck Residential Care Home

Inspection report

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Date of inspection visit:
15 July 2022
10 August 2022

Date of publication:
22 September 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
Stanbeck Residential Care Home is a residential care home providing personal care for up to 13 people. The service provides support to older people. At the time of our inspection there were 10 people using the service. The service accommodates people in one adapted building.

People's experience of using this service and what we found
People were at risk of harm as fire safety had not been managed effectively. We made a referral to the fire service following our inspection. Systems were not fully embedded to support the safe and proper use of medicines for people. Although staff were knowledgeable about risks to people, this information was not always reflected in people's care records, in particular for people with diabetes. While visitors were able to see their family members and friends, the visiting arrangements did not reflect current guidance. We made a recommendation about the provider's visiting policy.

The provider did not have oversight of the service to ensure people were receiving effective care. Systems were not established to support the monitoring of the service to monitor it and identify any improvements needed. Whilst there were shortfalls with the provider's systems, people's experiences of their care were positive. They complimented the staff on their approach. The registered manager was fully involved with the service and regularly spoke to people about their care.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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 good (published 01 January 2020).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to initial inquiries to determine whether to commence a criminal investigation. 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 bed rails, risk management and staffing.

We undertook a targeted inspection to follow up on these specific concerns which we had received about the service. A decision was made for us to inspect and examine those risks.

We inspected and found concerns with fire safety, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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?

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.

Stanbeck Residential Care 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.

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 carried out by one inspector.

Service and service type
Stanbeck Residential Care 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. Stanbeck Residential Care 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

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, including feedback from the local authority. The provider did not complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. Due to the COVID-19 pandemic we asked providers to return this information to us on a voluntary basis. We used all this information to plan our inspection.

During the inspection
We spoke with three people that used the service and two relatives about their experiences of the care provided. We spoke with seven members of staff including the registered manager, deputy manager, maintenance worker, care workers and a domestic.

We reviewed a range of records. This included six people's care plans in part and multiple medicines records. We reviewed three staff recruitment and supervision records. A range of records relating to the management of the service, including quality assurance checks, health and safety records and a sample of the provider's policies and procedures were viewed.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management
- Fire safety was not effectively managed to keep people safe.
- The service did not have compartmentation in to prevent fire spreading. Doors throughout the service were held open via wedges, preventing them providing any fire resistance.
- The provider's fire evacuation plan and staff fire training did not prepare staff for how to respond appropriately to keep people safe in the event of a fire.
- Recommendations made in the fire risk assessment from 2014 had not been acted on to remedy any fire safety issues.

We found no evidence people had been harmed. However, the provider had failed to assess and lessen risks to people's health and safety and ensure the premise was safe for its intended use. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We made a referral to the local fire and rescue service during our inspection to further review fire safety risks and support the provider.
- Following out feedback and feedback from the fire and rescue service, the registered manager had made changes to fire evacuation arrangements and briefed staff on these.

- Records were not always in place to identify risks to people and measures in place to keep them safe.
- Risks linked to people's diabetes had not always been recorded to show how these had been assessed, monitored and reduced. One person was prescribed insulin to manage their diabetes, no risk assessment was in place to inform staff about how the person's diabetes affected them or guide them in how to respond.
- The provider used CCTV to monitor people's safety and the premises. There was no evidence people and their relatives had been informed of the use of CCTV. A risk assessment had not been completed to support the safe use of this equipment.

We found no evidence people had been harmed. However, the provider had failed to assess, monitor and reduce risks to people and maintain complete records of their care. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were knowledgeable about risks to people and how best to support people with managing these.
● The registered manager was aware of risks linked to diabetic health and worked with health professionals to manage these appropriately.
● Health and safety checks were carried out to check equipment within the service was safe and in working order for people using the service. These included beds and call bell checks.
● Staff understood the support people needed with any behaviours that challenged and managed these effectively.

Using medicines safely
● Systems were not always in place to support the safe management of medicines.
● Medicines waiting for disposal were not recorded in-line with guidance to keep track of these medicines and protect people from their misuse.
● 'As and when required' protocols were not in place to guide staff when to administer these occasional medicines to people.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection, the registered manager updated medicines for disposal records and started to change medicines systems to improve their safe use.
● Medicines competencies were completed by staff prior to being able to administer medicines to help ensure they had the knowledge and skills to provide this support to people safely.
● People received their medicines as prescribed.
● Staff knew how to identify if people required 'as and when required' pain relief. One care worker told us, "If [person] is in discomfort you can see it from [person's] facial expressions."

Staffing and recruitment
● Full recruitment records had not always been maintained to show the checks the provider had carried out to support the safe recruitment of staff.
● The registered manager had not retained Disclosure and Barring Service (DBS) certificates.
DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

We found no evidence people had been harmed. However, the provider had failed to maintain securely records for staff employed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although recruitment checks had not always been recorded, the registered manager had carried out appropriate recruitment checks to safely recruit staff.
● On day two of the inspection the registered manager provided a copy of a DBS certificate to show the required checks had taken place.
● There were enough staff on shift to safely support people. One person said, "There are enough staff to help."
● The service had a well-established team of care staff, who were experienced and provided consistent support to people.
● Staff received an induction to the service to help them familiarise themselves with the service and the provider's ways of working.

Visiting in care homes
● Visitors were able to visit their friends and family members living at the service. The registered manager understood the importance of visiting to people's wellbeing.
● People and their relatives were satisfied with the visiting arrangements.
● The provider's visiting arrangements was not in-line with current government guidance. The policy required visitors to carry out testing prior to attending.

We recommend the provider reviews and update their visiting policy.

Preventing and controlling infection
● We were not assured that the provider's infection prevention and control policy was up to date.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

Learning lessons when things go wrong
● It was not always clear whether people's care records and risk assessments were updated in response to accident and incidents.
● Accidents and incidents were not analysed by the registered manager or provider to look for any trends and patterns and consider any wider learning needed.
● Staff knew how to respond following accidents and incidents and when to seek medical advice.
● Accident and incident records were maintained to provide accounts of what had happened.

Systems and processes to safeguard people from the risk of abuse
● People felt safe living at the service and told us staff would provide them with support if needed. One person said, "I can get help here if I need it, all I have to do is pull that wire [call bell]."
● Staff were able to identify signs people may be at risk or experiencing abuse. Staff followed the provider's processes to raise any concerns with the registered manager.
● Staff understood how to escalate their concerns to other organisations if they had concerns about the provider's response.

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 MCA 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 take 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is

usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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 care.

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

- There was no evidence of the provider having oversight or involvement in the running of the service.
- There was no established quality assurance system. The provider had not completed any quality assurance checks. The registered manager had carried out some audits, however these did not cover all areas such as care records and infection prevention and control.
- The provider's policies and procedures were not specific to the service and did not always reflect practices observed. For example, the medicines policy referred to 'as and when required' records, which were not in place.
- The registered manager and provider had not identified the issues we found, including with fire safety, medicines systems, accident and incident monitoring, care records, recruitment records and the provider's policies.
- A full record of staff training was not in place to enable the provider to have oversight of this and identify any gaps to be addressed.

We found no evidence people had been harmed. However, the provider had failed to have effective systems in place to assess, monitor and improve the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was responsive to our feedback and had started to make changes based on this.
- Staff were clear about their roles and responsibilities; they understood the importance of sharing information about any incidents and risks to people to provide people with consistent care and support.

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

- The registered manager led by example; they were actively involved in people's day to day care and ensured this was provided to a high standard.
- The registered manager was passionate about person-centred care and advocated on behalf of people to access support they needed from health and social care services when needed. Staff shared this commitment to supporting people. One care worker said, "I love the people here, I love my job. I should be retiring but I have too much energy to do that."
- People were satisfied with their care and the approach by staff to providing this. One person told us, "I like

it here because all the staff are fantastic."

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 registered manager understood their responsibility to submit statutory notifications for events they were required to notify CQC of.

● When things went wrong, the registered manager apologised to people and their relative or representative and provided an explanation of what had happened.

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

● The registered manager regularly spoke with people and their relatives to seek their feedback on the service and any changes needed.

● Staff felt able to raise any issues with the registered manager and able to make suggestions. One care worker told us, "The registered manager would listen if I had feedback."

● The registered manager responded to any concerns or complaints raised by people and their relatives in a timely way.

Working in partnership with others

● The service worked in partnership with other health and social care services to meet people's care needs and deliver effective care.

● The registered manager kept themselves up to date with any updates and changes to processes for accessing healthcare services.

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 The provider had failed to ensure premises were safe for their intended use. The provider had failed to have robust systems in place to support the proper and safe management of medicines. 12(1)(2)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have systems in place to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain complete records of people's care and staff employed. 17(1)(2)(a)(b)(d)(i)