Amber Care Limited

# Stonebow House Residential Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

About the service:
Stonebow House is a residential care home providing accommodation and personal care to for a maximum of 30 people. There were 20 people living there at the time of inspection.

People's experience of using this service:

• Risks associated with the home environment had not been assessed.
• There was not an effective system in place to identify, action and learn from identified risks.
• People were not always treated with dignity and respect.
• People were not always consulted with about aspects of their home and the management of risks.
• Staff had relevant training to perform their roles effectively.
• Staff felt supported by the registered manager.
• There were systems in place to protect people from the risk of abuse and harm.
• People were supported with their nutritional needs and had choices with meals.
• Medicines were managed safely.
• People were able to access external health professionals and were supported with their needs when required.
• More information is in the Detailed Findings below.

• We identified two breaches of Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Rating at last inspection:
• At the last inspection on 18 April 2018 the service was rated 'Requires Improvement'. At this inspection, the rating for the service has remained at 'Requires Improvement'.

Why we inspected:
• This was a planned inspection based on the rating of the last inspection.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not always safe.<br>Details are in our Safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our Effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our Caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our Responsive findings below. | **Good** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our Well-Led findings below. | **Requires Improvement** |

# Stonebow House 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector and an assistant inspector.

Service and service type:
This service is a care home for elderly people and is registered to accommodate up to 30 people. 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:
The inspection was carried out on 4 and 5 April 2019 and was unannounced. This means the home was not aware we were coming to inspect them.

What we did:
Before the inspection, we reviewed relevant information that we had about the service including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events, which the provider is required to tell us about by law. We also checked

the last inspection report.

The service completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make.

During the inspection we spoke with the provider, registered manager, six care staff, a visiting health professional and five people using the service.

We looked at the care records of four people who used the service. The management of medicines and a range of records relating to the running of the service. This included audits, premises safety checks, complaints and accident and incident 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.

Requires Improvement: 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. Regulations were not being met.

Assessing risk, safety monitoring and management:
• People were at risk as the provider had not taken all reasonable steps to ensure the health and safety of people using their service.
•People were not always safe. There was a lack of environmental risk assessments in place to ensure people were always safe.
• There was a lack of effective management of the environment to reduce risks to people's health and safety. A cupboard that contained chemicals harmful to health was not locked in an area where people had unrestricted access. Action was taken by the provider to ensure all areas were made secure once brought to their attention. However, this risk had not been identified by them prior to the inspection.
• A fire evacuation sheet and slide mats were not accessible in the event of a fire. This would hamper any attempts to evacuate people that required assistance with mobility. Also, door guards that made sure people's doors closed in the event of activation of the fire alarm, were faulty. We ensured that action was taken by the provider to immediately rectify these issues. Following the inspection, we shared information with the local fire service who inspected and found the provider was compliant with current fire legislation.
• Water temperatures in people's rooms had been recorded by maintenance staff on the day of our visit. The measurements showed 25 of the 28 temperatures obtained were too low and identified by the provider's own policy as putting people at risk of exposure to Legionella. Legionella is a serious waterborne disease that is harmful to health. We have asked the provider to take steps to identify and rectify the cause of the low water temperatures .
• People's wardrobes were at risk of tipping onto people as they were not securely fixed to people's walls.

Preventing and controlling infection:
• The systems to reduce the risk and spread of infection were not effective at reducing the risk to people. Although staff had knowledge and training in infection control there were insufficient facilities for the safe, hygienic disposal of soiled waste. Not all areas of the home were kept clean and tidy. Bathrooms were not always clean and hygienic. One bathroom had exposed plaster and brickwork and posed a risk of infection.

Learning lessons when things go wrong:
• Where the registered manager had information relating to incidents or accidents, they had demonstrated that measures were taken to reduce risk. However, important information relating to risks that was known by the provider and by the maintenance staff support team, were not consistently shared with the registered manager. This meant action was not always taken to review and identify any factors that could take place to reduce future occurrences. For example, the registered manager was unaware of the issues with water temperatures, so was unable to share and work with care staff to reduce the risks to people.

The above issues show the provider failed to ensure the proper and safe management of risks and this placed people at risk of potential harm. The issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risk of abuse because there were processes in place to minimise the risk of abuse and incidents.
• Staff and the registered manager understood their responsibilities to protect people from abuse. Staff were able to tell us what they would do and who to contact if they suspected abuse.
• Staff told us that if they had concerns they were aware of when to whistle blow and of the role of organisations like the local authority and CQC.

Staffing and recruitment:
• There were recruitment systems to undertake the relevant checks to ensure that new staff candidates were suitable to work with vulnerable people.
• There were sufficient numbers of staff to provide people with support when they needed,
• The provider recruited regularly to maintain staffing levels and covered any absence with employed staff or used agency staff. The registered manager told us that they tried to ensure that where possible the same agency staff were used to promote consistency for people that used the service.

Using medicines safely:
• At the last inspection on 18 and 20 April 2018, inspectors found medicines were not managed safely. At this inspection, we found improvements had been made in how medicines were managed.
• The provider had systems and procedures to ensure that medicines were ordered, administered and disposed of appropriately.
• People received their medicines in line with their prescription and from staff that had the training and knowledge to do this safely.
• Medicine records were accurate, complete and up to date. The provider had a system to audit records and follow up any gaps or mistakes in records.

Requires Improvement

# 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.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs:
• The premises and environment did not always meet the needs of people who used the service. Whilst people's bedrooms were personalised with pictures and some personal furniture, communal areas were poorly maintained. For example, there were inadequate bathroom facilities. One bathroom that was accessed independently by a person who had recently lost their sight had trip hazards including a heater and a wheelchair. There was loose masonry and plaster on the walls and exposed hot pipes next to the toilet. The person could not see the risks and was unaware of these risks when they were informed. The provider agreed to close this bathroom until work had been completed to rectify the risk.

Staff support: induction, training, skills and experience:
• Staff completed an induction prior to working completely alone, this included training and shadowing alongside experienced staff.
• Staff completed a range of training relevant to their roles. This included moving and handling, medicines, safeguarding and the Mental Capacity Act. Staff felt training was sufficient to enable them to carry out their roles effectively.
• There were systems to monitor staff training and identify when staff needed refresher training to maintain their skills.
• Staff told us that the newly appointed registered manager had already improved the support and supervision that they received as a staff team. There were systems to monitor staff training and identify when staff needed refresher training to maintain their skills.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's health and care needs were assessed prior to the start of their care. This made sure that staff understood what needs were to be met.
• Where needed, the provider and staff liaised with other health and social care professionals such as nurses and doctors. Staff followed advice and guidance given by these professionals in a timely and effective manner. For example, a visiting health professional told us, "Staff always action requests and ring if they are concerned."
• Staff told us care plans and risk assessments contained the relevant information they needed to support people according to their needs and choices.
• People felt care and support met their individual needs. One person said, "They look after me well here."

Supporting people to eat and drink enough to maintain a balanced diet:
• People were offered choices for their meals and told us that they liked the food.

• We observed staff support people over the mealtime. We found that people had the support that they needed to enjoy their food and drink. However, there was a lack of chatter and interaction from staff with people.
• Where needed, people's food and fluid intake was monitored by staff and any concerns were referred to the relevant health professionals.

Supporting people to live healthier lives, access healthcare services and support:
• People had access to any healthcare services they required, such as doctors, dentists and hospitals.
• Staff knew people's healthcare needs and when a person may be unwell.
• Staff requested support from health professionals when required and followed any advice given.

Ensuring consent to care and treatment in line with law and guidance:
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 Act 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 with appropriate legal authority. 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 Act.
• Records showed people consented to their care and support plans.
• Staff supported people's choices and sought consent each time they supported people with personal care.
• Staff received training in the Mental Capacity Act 2005 and understood how to make best interest decisions if people lacked capacity.
• The MCA and associated Deprivation of Liberty Safeguards (DoLs) were applied in the least restrictive way and correctly recorded.

Requires Improvement

# 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

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity:
• People told us that they felt staff were kind and caring. We saw that staff had good relationships with the people they supported. However, we saw occasions when staff had not thought about how their actions may be perceived. For example, at lunch staff were waiting next to people eating ready to take their plates, with arms folded and no interaction. We also saw occasions where staff had not placed themselves at eye level with the person before talking with them. We spoke with staff about this who told us that they would ensure that they changed the way they interacted with people. The registered manager also told us that they recognised this was not best practice for communicating with people and would do some awareness training with staff around positive interactions.
• Staff understood the principles behind equality, diversity and human rights. We were assured that whatever denomination, sexual preference, gender or faith that no one would be prejudiced in any way.

Supporting people to express their views and be involved in making decisions about their care:
• Some people were supported to pursue hobbies and interests. We could see where staff had helped a person adjust how they carried out a hobby, due to their gradual sight loss. However, one person we spoke with who had lived there for several years, had recently experienced almost total loss of sight due to illness. They told us that they were trying to maintain some independence and told us, "I am finding it difficult to accept. I get lonely as I now stay in my room and staff do not always have the time to spend with me." With the person's consent, we discussed how they were feeling with the registered manager who told us that they would spend time with the person and with staff to look at how they could improve the experience for this person.
• The registered manager told us of their plans to improve how they captured the views of people living at Stonebow House as there was currently no consistent way of gathering people's views of their care. People did not always have a say in how their home environment was maintained or decorated, and areas of the home were lacking care and attention. For example, very worn carpets in communal areas, untiled and unclean bathrooms.

Respecting and promoting people's privacy, dignity and independence:
• Staff treated people with dignity and respect when providing personal care.
• The environment did not always reflect or promote people's rights to privacy, dignity and respect. Members of the public walking around the home were able to see what continence products people were using as these were placed near people's doorways. Also, there was a post and electoral roll list that detailed people's names and room numbers in the reception area. Any person visiting the home would be able to view people's personal and confidential information.

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Care plans detailed people's support needs. Care plans included information on how to support people with personal care, nutrition and continence. Families were involved in care planning via meetings with the registered manager, where appropriate.
• Staff were aware of people's care needs and were able to describe what was needed to support people to achieve their care goals, such as frequency of repositioning to maintain healthy skin.
• Staff had hand held electronic devices to support them in recording care delivered. These also sent reminders to staff about points of care that needed specific attention, such as recording people's fluid intake. The staff stated that these were a good idea, and the provider had increased their information systems, to allow staff better access.
• There was inconsistency regarding staff knowledge of people's lives. They were aware of the facts, but were not always aware of detail, and were inconsistent in their approach to providing activities that fed into this. The registered manager was aware of this and told us that she was in the process of working with staff to expand the activity programme, and ' Who Am I?' books were being implemented to provide more detail about people to enable them to be supported with hobbies and interests.
• One person told us, "I enjoy the trips, we've been for a trip on the canal, and to the Worcester races"
• People were taking part in a sweepstake for the Grand National, and other people were being supported to do what they wanted like reading or doing puzzles
• Staff were aware of people's communication ability and how to communicate with people effectively.
• We observed communication between people and staff was positive and considerate of sensory loss introducing themselves as they walked into the room of a person with sight loss.
• The registered manager had introduced a happiness planner, which was used to access people's moods and responses to events that occurred to try to identify patterns and take the appropriate action to mitigate feelings of anxiety and low mood

Improving care quality in response to complaints or concerns:
• All complaints were recorded along with the outcome of the investigation and action taken.
• People were aware of how to make complaints, there was signage in the home to inform people of how to do this.

End of life care and support:
• Where possible, end of life care had been discussed with people.
• These included people's preferences with end of life care and their preferred burial.
• Do Not Attempt Resuscitation forms were in place in people's care plans. These were also audited by the registered manager to ensure the information was accurate and signed by relevant health professionals. A list was available in the registered manager's office.

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.

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• Quality assurance systems in place were not used effectively.
• The provider had failed to identify and action risks to people's safety and welfare in a timely manner. We found that where there had been external audits which had identified recommendations to improve safety, there had been delays in implementing improvements. For example, an external fire audit undertaken on 4 March 2019 identified that 'slide sheets should be positioned appropriately to those residents with poor mobility.' However, during our visit on 4 April 2019, we found slide sheets and a fire evacuation slide mat inaccessible in the event of an emergency.
• Quality assurance systems had failed to identify the environmental risks to people's safety. For example, the unlocked doors and the inaccessible fire equipment that we found during inspection.
• The provider had taken immediate action to mitigate the most urgent risks, for example the fitting of locks on doors where areas posed a danger and the relocation of fire evacuation equipment. However, this action was only taken when we made him aware of the risks and did not reflect an approach that was proactive in identifying and managing risk.
• This meant that there was a risk people may not receive high quality care to ensure they were safe at all times.

Continuous learning and improving care:
• Accidents and Incidents were recorded and analysed to identify any emerging trends and patterns. However, the registered manager was not aware of all of the risks, as the provider had not communicated them effectively. This meant that the registered manager could not take steps with staff to reduce the risks around the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The provider had not taken the necessary steps to ensure people that lived there were engaged in the management of risk and quality issues in the home. For example, people were not informed of the exposure to risks around fire safety and water safety.
• After the inspection, the provider sent us an action plan outlining the actions they are taking to strengthen audit and management processes.

The above issues show the provider failed to ensure robust audit systems were in place to identify shortfalls

and act on them to ensure people were safe at all times. The issues related to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Staff told us the registered manager was approachable and understanding. They felt supported and the registered manager told us they were implementing improved systems of staff support and supervision.
• Effective communication between the provider and registered manager did not always take place. We discussed this with the provider who was going to review the sharing of information with the registered manager.
• The registered manager reported incidents correctly and demonstrated a clear understanding of the types of incidents to be reported to the CQC.
• The provider had displayed their rating both in the home and on the website which provides information about their services and links to their latest CQC rating.

Working in partnership with others:
• There was a good working relationship with other agencies such as doctors, pharmacies, and district nurses. Staff followed any professional guidance provided.

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<br><br>The provider failed to ensure the proper and safe management of risks and this placed people at risk of potential harm. The issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure robust audit systems were in place to identify shortfalls and act on them to ensure people were safe at all times. The issues related to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. |