Stonesby House Ltd

Stonesby House LTD

Inspection report

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21 October 2020
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03 November 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Stonesby House Ltd is a residential care home registered to provide accommodation and personal care for up to 14 adults who may be living with mental health needs and/or learning disabilities or autistic spectrum disorder. At the time of our inspection, thirteen people were using the service.

People's experience of using this service and what we found
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 guidance CQC follows 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. People did not always receive person-centred care and treatment that was appropriate to meet their needs and reflected their personal preferences. Their care and support did not always promote enablement, independence, choice and inclusion. The systems in place to prevent and respond to crisis situations, including training in positive behaviour support, and learning from incidents was not always used safely and effectively.

People were not always protected from the risk of harm or abuse because the systems and processes in place to safeguard people were not effective. Incidents of potential abuse were not always identified or reported to the relevant authorities.

Care plans and risk assessments did not contain adequate information for staff to know how to support people safely when they became distressed. There was a lack of effective training for staff to support people when they became distressed which put them at increased risk of harm. Staff had developed inappropriate and unsafe strategies to manage incidents when people had become distressed and anxious.

There was no effective system in place to monitor maintenance and health and safety aspects of the service, including the management of Legionella.

People's care did not support them to learn new skills, become more independent and achieve good outcomes. Care plans did not record people's goals or celebrate their achievements.

Infection control procedures were not sufficient to reduce the risk of infection, particularly in the time of the current pandemic. Government guidance to protect people living in care homes during Covid 19 were not adhered to. Systems in place to ensure the proper and safe management of medicines were not robust and did not ensure people received their medicines as prescribed.

Robust recruitment checks had not been completed to ensure only suitable people were employed to work

at the service. The provider did not use a systematic approach to determine staffing numbers. Staffing numbers were insufficient to meet people's needs and keep them safe.

There were no lessons learned protocols in place so the provider could learn from incidents and accidents, safeguarding concerns and complaints to improve the quality of the service. Following incidents where staff had supported people when they became distressed, there was no debrief for staff so that lessons could be learned, and new strategies introduced to improve care.

There was a lack of effective quality assurance processes in place to monitor the quality and safety of the service.

We found that oversight and leadership of the service was not effective. Staff told us they were not encouraged to raise concerns with management and did not feel supported in their roles. Feedback from people and staff was not acted upon and the provider had failed to act upon people's concerns to drive improvements at the service.

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 28 June 2019)

Why we inspected:
We received concerns in relation to insufficient staffing numbers, poor practices regarding infection control, a lack of staff training, poor and unsafe environment and poor leadership and management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 coronavirus and other infection outbreaks effectively.

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 Requires Improvement to Inadequate. This is based on the findings at 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stonesby House Ltd 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 safe care and treatment, safeguarding service users from abuse,

staffing and good governance.

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
Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not Well-led.

Details are in our Well-led findings below.

Stonesby House LTD

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 carried out by three inspectors, a Legionella Specialist Advisor and an expert by experience. 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
Stonesby House Ltd 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
We gave a short period of notice for the inspection because we wanted to be sure the provider had an Infection Control procedure and Covid 19 risk assessment in place. We did this so we could adhere to their policies and follow government guidelines in relation to social distancing.

What we did before the inspection
We reviewed information we had received about the service since the last inspection as well as recent

safeguarding concerns that had been raised. We sought feedback from the local authority and other professionals who worked with the service. We used all of this information to plan our inspection.

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
This inspection took place over two days. On the first day we spoke with four people who use the service and four relatives by telephone to gain feedback about their experience of the care provided. We had discussions with the registered manager, the assistant manager and two care and support staff on site.

We reviewed a range of records. These included four people's care records and risk assessments. 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 quality assurance checks and safeguarding information was also examined during the inspection. We spoke with a further four staff by telephone on 23 and 26 October 2020.

On the second day of our inspection we checked to see if the provider had taken urgent action to address the most serious risks outlined in this report and found that some improvements had been made to infection control and prevention, risk management and the environment. We also looked at staff training records and spoke with nine staff by telephone on 02 and 03 November 2020.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested records in relation to training data, accident and incident reporting, care plans, staff rotas and quality assurance audits.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm

Assessing risk, safety monitoring and management

- People were at risk of harm because risk assessments were not always in place for identified areas of risk. For example, one person had been assessed by the Speech and Language Therapist (SALT) team to be at risk from choking, however there was no risk assessment in place to reduce this risk.
- Risk assessments and care plans did not contain enough guidance for staff to know how to respond to people when they became distressed. For example, one person frequently needed support and understanding when they become distressed and destroyed furniture or threw objects at others. There was no detailed guidance in their care plan for staff to follow and no risk assessment in place to reduce risks to people.
- Where there was information in care plans for staff to follow, they did not always provide care in line with the guidance. For example, records detailing one person's behaviour showed that on several occasions the person had become distressed, triggered by an inappropriate approach from staff.
- Care plans did not contain information about the use of restraint and staff told us they were not trained to use restraint. However, one staff member told us, "We used restraint on [name of person] recently. They wanted attention and became quite disruptive. Staff had to force [name of person] out of the lounge."
- Another staff member informed us, "When I raised concerns about risks to people and staff because of the low staffing numbers, the [senior staff member] told us to restrain [name of person] even though we're not trained."
- There was a lack of effective training for staff to support people when they became distressed. Staff had developed inappropriate and unsafe strategies to manage incidents. For example, we observed that staff had used a bicycle lock to lock two fire doors to keep two individuals apart. This put people at risk if there was a fire. Some staff told us they responded to incidents by standing between people to protect them. This had resulted in staff being assaulted and put staff and others at risk of harm.

Following the first day of our inspection the provider sent us a copy of the risk assessment for the person who had been identified to be risk of choking by the SALT team. The provider also sent us confirmation that they had arranged for Legionella training for key staff to improve the management of Legionella. The bicycle lock was removed from the doors.

Preventing and controlling infection

- Infection control procedures were not sufficient to reduce the risk of infection, particularly in the time of the current pandemic. Government guidance to protect people living in care homes during Covid 19 were not adhered to.
- Personal Protective Equipment (PPE) was not easily accessible to staff throughout the building, so they

could change their PPE when required. Comments received from staff included, "PPE is all locked up." And "We get one mask to use for the day. So, on a 12 hrs shift we have to use the same mask even after our break." And "The manager keeps questioning us why soap, gloves and masks are finished. They [meaning management] don't care about us [staff] or the residents; only using up PPE and the cost to replace it." Some staff told us that they had to purchase their own PPE to stay safe.

● There were no specific areas for staff to don and doff (putting on and removing personal protective equipment) their PPE. Donning and doffing procedures were not being followed. We observed poor practice where staff wore masks that were below their nose and some staff wore non-medical fabric masks. This meant that people and staff were not protected from the control and spread of infection.

● Paper towels, hand washing facilities and hand gels were not available throughout most of the service. The sink in the laundry area in unit B was not accessible to staff as broken furniture and pots of paint were stored in the laundry room in front of the sink. In one bedroom we saw a toilet frame that had brown faecal matter on it. There was also an incontinence pad next to the toilet frame that had brown faecal matter on it.

● Governance of Infection Control did not identify areas for improvement. The last Infection Control audit completed in Sept 2020 did not identify any areas that required improvement for example, the lack of hand sanitisers and the unpleasant odour and severe damp on the walls and carpet in one person's room.

Following the first day of our inspection the provider installed wall mounted hand sanitisers and paper towel dispensers and PPE was made more readily accessible to staff throughout the home. Some areas of the home had been cleaned.

Using medicines safely

● Systems in place to ensure the proper and safe management of medicines were not robust. We saw that Insulin was stored in a fridge that was not locked. We found three bottles of eye drops that were opened in April 2020 and had not been discarded. There was also a tube of cream that had been opened in April 2019 and had not been discarded. This put people at risk of receiving out of date medicines.

● Some staff told us that they had not completed accredited medicines training to ensure they had the skills to administer people's medicines safely. One staff told us, "The training wasn't extensive. [Senior staff member] showed me how to give medication. They observed me once and signed me off after a discussion."

● Medication Administration Records (MAR) contained hand-written entries that were not dated and signed by two staff in line with best practice. Some hand-written entries were not always written legibly. This put people at risk of receiving the wrong medication.

● The register to record some specific medicines administered by staff did not always demonstrate best practice. For example, two staff had not always signed the register to confirm the medication had been given. There were gaps in MAR charts where staff had failed to sign to confirm they had administered people's medicines.

● Medicines audits were not effective at identifying errors and gaps in records. Some staff told us they had not received accredited medicines training.

The provider had not ensured people received safe care and treatment. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

● People did not always feel safe living at Stonesby House Ltd . One person told us, "There is one person who lives here that makes me feel unsafe. They shout and throw things." Another talked about the same person living at the service who they said they found threatening and told us how their behaviour upset them.

● Staff told us they were not supported to raise concerns. Comments from staff included, "Staff are fired for raising concerns. We're not protected." And "She [meaning registered manager] says that's the door, you can go." And "Staff are bullied when you raise concerns."
● There had been assaults on other people using the service and inappropriate strategies used to manage these incidents. Not all incidents and accidents had been reported to CQC or safeguarding. Following incidents where staff had supported people when they became distressed there was no debrief for staff, so that lessons could be learned, and new strategies introduced to improve care and staff practice.
● People's risk assessments and care plans were not reviewed and analysed following accidents and incidents to reduce risks to people. This meant that the lack of investigation and analysis of accidents and incidents failed to ensure improvements were made to people's care and support.

The provider failed to protect people from potential abuse and improper treatment. This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

Staffing and recruitment
● People were placed at potential risk because recruitment processes and procedures were not followed consistently. Staff had been recruited without all the appropriate pre-employment checks being carried out.
● All the staff we spoke with said there were insufficient staff working at the service. Comments included, "Always short staffed. Should be nine in the morning but there's only four." And "There are daily staff shortages. Today there should be five in one unit and four in the other, but there's only two and three staff this afternoon." And "Mistakes are happening with medicines because staff are doing the medication rounds and having to do personal care, cooking and cleaning in between."
● Six people using the service required either 1 -1 or 2-1 care so their needs could be met. Staff rotas demonstrated that people did not receive the support hours they needed to meet their needs.
● On the day of our visit there was a shortage of staff and the person who required 2-1 support did not receive the required support. We saw this individual needing support and understanding because they were distressed, and the staff member had to support them on their own due to the lack of staffing. This put the person, others and staff at risk of harm and injury.

The provider had not ensured people received care from sufficient numbers of staff who were suitably qualified, skilled or competent. These concerns constitute a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

Inadequate

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 now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- Staff did not feel valued or well supported and told us the registered manager did not maintain a visible presence. Comments included, "Manager never helps, she sits in the office out of the way." And "Management should lead by example, be the backbone of the home and know each resident and their needs. She [meaning registered manager] doesn't know anything other than their name."
- There was a lack of managerial oversight regarding staff training. One staff member told us, "The manager isn't involved in training. She doesn't check we've understood the training." Training records were disorganised and did not evidence what training was needed to ensure staff had the skills and knowledge required to meet people's needs.
- Staffing deployment wasn't assessed or monitored to ensure people's safety. We found staff deployment to be inadequate during our inspection. Staff were unable to deliver safe care and support due to the staffing skills mix and numbers, however, the registered manager and the provider had not identified this as an issue.
- There was no effective system in place to monitor maintenance and health and safety aspects of the service, including the safe management of Legionella. Most areas of the service were in a state of disrepair and we found gaps in records for the management of Legionella. Staff responsible for the management of legionella were unable to demonstrate sufficient knowledge of the risks posed from legionella or identify appropriate control measures to manage the risks.
- The registered manager and provider did not fully understand the regulatory requirements regarding submitting legally required notifications to the Care Quality Commission (CQC) and other relevant authorities. They had not notified us of some incidents or allegations of abuse.

Continuous learning and improving care

- There was a lack of provider oversight to ensure systems in place were being followed and used to drive improvement. For example, although the registered manager completed quality monitoring checks in relation to care plans, the environment, medication and infection control they had failed to identify issues or areas of concern so that improvements could be made.
- There was no evidence of learning, reflective practice and service improvement. Robust systems were not in place to record, review and analyse incidents and opportunities to learn from incidents and mitigate further risks had been missed.
- There was a lack of managerial oversight of how staff recorded information about people using the service. For example, we looked at the behavioural records for three people. We found some of the

terminology used to be unprofessional and derogatory about them but had not been identified through the providers governance systems.

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

● A person-centred and inclusive culture was not promoted. People told us they were not involved in their care planning. One said, "I don't know about a care plan. I don't know what's in it." A staff member told us, "Care plans are not person centred, they have no information about the person, what they like and dislike, what goals they have, what can upset them and what diversion we should be using."

● The registered manager and provider had failed to identify that staff had developed inappropriate and unsafe interventions when supporting people with their behaviours. This put people at risk of harm and did not ensure good outcomes for people.

● The service did not always work openly, inclusively or in an empowering way, which meant people did not always have a good quality of life. Staff interactions with people were task focused. Some staff were not communicative and did not always engage positively with people. We observed that some staff did not always listen effectively to what people wanted and did not engage with them on a meaningful level.

● Care plans did not record that service users, families and relevant health professionals had been involved in the planning, reviewing and evaluating all aspects of a person's care and support.

● People's care did not empower them to gain new skills, become more independent and achieve good outcomes. Care plans did not record people's goals or celebrate their achievements.

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

● The registered manager and provider did not effectively involve and engage with people. Where people had raised concerns there was no record of any actions taken. For example, one person had recorded that staff did not help them to speak up for the things they needed. There were no actions recorded of how or if this had been addressed.

● Feedback had been gained from staff by the use of a satisfaction survey. However, we found comments about any shortfalls had not been actioned. For example, one staff member made a comment about a person's carpet that had a very offensive odour and asked if it could be replaced. There was no action recorded about how this had been addressed and on the day of our inspection we saw the carpet was still in place and still had a very offensive odour.

● Staff told us they were not encouraged to raise concerns with management. Staff had raised concerns with the Care Quality Commission about a lack of staffing, a lack of staff training, in particular in relation to supporting people when they became distressed, infection control procedures and risk management.

● Staff meetings and staff supervision were not consistent. Staff told us these had stopped during the pandemic. This meant staff had no platform to raise concerns or new ideas.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. The provider failed to seek and act on feedback provided or concerns raised to drive improvement at the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Working in partnership with others

● The registered provider had not been responsive to issues and concerns. Incidents were not always shared with people using the service and their families in line with the duty of candour.

● The registered manager, provider and staff did not always work in partnership with key organisations such as the local authority, safeguarding teams and clinical commissioning groups, the police and multidisciplinary teams, to support care provision. This meant that people using the service did not experience joined up care based on good practice and people's informed preferences.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from abuse and improper treatment. There had been assaults on other people using the service. Staff were not supported to raise concerns about potential abuse.

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 The provider had not ensured people received safe care and treatment. Risk assessments were not always in place for identified areas of risk and did not contain enough guidance for staff to know how to respond to people's behaviour to keep themselves and people safe. Infection control procedures were not sufficient to reduce the risk of infection. Systems in place to ensure the proper and safe management of medicines were not robust.

The enforcement action we took:

Notice of Proposal to impose a positive condition in relation to the safe care and treatment of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. The provider failed to seek and act on feedback provided or concerns raised to drive improvement at the service.

The enforcement action we took:

We issued a Notice of Proposal to impose a positive condition in relation to good governance, leadership and management at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured people received care from sufficient numbers of staff who were suitably qualified, skilled or competent.

The enforcement action we took:

We issued a Notice of Proposal to impose a positive condition in relation to ensuring sufficient staffing.