Interhaze Limited

Stanbrook Care 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Stanbrook Care Home is a residential care home providing personal care to 25 people aged 65 and over. At the time of the inspection 14 people were being supported by the service. The accommodation is provided in one adapted building with bedrooms on the ground and first floor.

People's experience of using this service and what we found
Risks were not always assessed to protect people from harm. There was insufficient guidance and monitoring in place for staff to support people who were at risk of constipation, dehydration, displaying distressed behaviours and manual handling. Where needs had been identified the service had not always responded in a timely way to address them. Accident and incidents were recorded but there was no robust oversight to learn from them and improve care in the future.

At our last inspection we found the provider's governance and auditing systems was inadequate and further improvement was needed to ensure people consistently received safe care. This remained a concern at this inspection. Audits were carried out by the management team and provider, but they had failed to ensure that people were always safe and their needs were being met. As a result, people were exposed to the risk of harm and inappropriate care. The provider's systems to ensure staff were competent and training was adequate were also not effective.

Most people told us they felt safe and staff were aware of how to protect people from potential abuse. People received their medicines as prescribed. We found some improvements in how the service supported people who had sore skin and with their oral hygiene.

Most people were positive about the food and told us they were given choices about what they wanted to eat. This was an improvement since the last inspection. There had been some recent changes to improve the environment, but further work was required to make it more homely and suitable for people living with dementia.

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. However, the policies and systems in the service did not always support this practice as some guidance in care plans did not evidence the least restrictive way to support people.

Whilst we saw many kind and caring interactions from staff, some people told us the support they received had not always respected their dignity. People and relatives were involved in their reviews and the service was taking action to involve people more in the decisions about the service.

Whilst the person-centred information in care plans had improved since the last inspection, further work was required to ensure identified needs were addressed in a timely way. We observed an improvement in

leisure opportunities on offer, although we still received mixed feedback in relation to this. People knew who to speak to if they had any concerns. People had an end of life care plan in place and further work was being developed in this area.

Rating at last inspection
The last rating for this service was requires improvement (published 06 November 2019) and there were multiple breaches of regulation. Following the inspection, a condition was placed on the provider's registration requiring them to complete monthly reports to show how they were improving.

At this inspection, enough improvement had not been made and the provider was still in breach of some regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

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

We are mindful of the impact of 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 to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
Special Measures:
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 the 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Stanbrook 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors 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
Stanbrook Care 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 did not have a manager registered with the Care Quality Commission. There was a manager in place who was managing the day to day running of the service and during the inspection we were advised they would apply to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed information from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with ten members of staff including the area manager, manager, senior care workers, care workers and the kitchen staff. 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 and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to take all reasonable steps to reduce risk associated with people's care which 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.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

● Where people had demonstrated 'distressed behaviour', care plans and risk assessments did not contain sufficient guidance for staff. Staff we spoke with were not always aware of potential 'triggers' for behaviour, and there was no robust review of incidents to identify triggers and develop strategies to support people.
● People were not protected from the risks of poor moving and handling practices. One person had no risk assessment in place, and staff had not followed the guidance on the care plan. This resulted in the person having an accident and experiencing pain.
● At the last inspection we found records did not contain guidance and staff were unclear about when someone was at risk of dehydration. This continued to be a concern at this inspection. Although we had no evidence anyone had been harmed, this placed people at increased risk.
● People were not protected from the risks associated with constipation. Although staff were maintaining records, there had been insufficient monitoring and no timely referral to health professionals when the risk increased. This meant the person had not been sufficiently protected from harm.
● A staff member tried to support someone to eat and drink when they were not fully awake and had their eyes closed. This is unsafe practice and could have placed the person at risk of choking.
● The provider had identified concerns about some staff's response to a fire drill in January 2020 and further training was required. At the time of our inspection this training had not been completed.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and area manager responded and acted upon all the above concerns both during and following the inspection.

● Improvements had been made since the last inspection to monitoring risks in relation to skin damage and

oral care.

Learning lessons when things go wrong
● Accidents and incidents were recorded however, there was limited evidence of lessons learned. For example, a physical restraint had been used to support someone with distressed behaviours. There was no robust analysis of this incident to discuss what happened, what support had been tried prior to the restraint and how to support this person if they displayed these behaviours again. Lessons learned had not been identified or shared with staff. This was not in line with the provider's behaviour policy and increased the risk of inappropriate care.

Staffing and recruitment
● People gave us mixed views on whether there were enough staff. One person told us, "There aren't enough staff, particularly in the morning or evenings. I can't get up or go to bed when I want as I have to wait." Another person said, "They always answer my call bell immediately."
● We found there were enough care staff to meet people's needs and people did not have to wait to receive care. We also saw staff carrying out activities with people and on one day a group of people went out to the pub.
● Some staff told us more staff were required to carry out activities with people. The provider had a dependency tool to assess the number of staff based on people's needs. This evidenced time for activities had been factored in.
● Staff were recruited safely. Robust pre-employment checks were carried out to ensure staff were suitable to work with people who may be vulnerable.

Systems and processes to safeguard people from the risk of abuse

At our last inspection people had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation

● Most people told us they felt safe. One person said, "I'm as safe as houses. The carers make me feel safe they do a grand job." Another told us, "I was a bit apprehensive initially but all in all I do feel safe."
● Staff had received safeguarding training and were able to describe the action they would take to report any concerns. One staff member said, "I would let the manager know and I can also ring the safeguarding team."
● Safeguarding referrals had been made to the relevant authorities where incidents of concern had taken place.

Using medicines safely
● People were supported with their medicines safely and told us they were happy with how medicines were being administered.
● At the last inspection concerns had been identified in relation to the recording of prescribed topical creams. At this inspection we found improvements had been made and there were records of where creams were being applied.
● The administration of people's medicines was recorded appropriately and medicines were stored safely.

Preventing and controlling infection

● Staff had received training in the prevention and control of infection and used personal protective equipment such as gloves and aprons where required. We saw evidence the service followed the correct guidance to manage infections and informed the relevant external agencies.

● People and relatives told us the environment and their bedrooms were kept clean and our observations confirmed this.

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.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs had not always taken place prior to them receiving support from the service. One person was moved to the service quickly and no assessment was in place. The service had difficulties in meeting this person's needs in the way they wanted and an accident had occurred. Their relative was also concerned that the service was not suitable and about the lack of communication from the service.

Staff support: induction, training, skills and experience

- Staff told us training was not always effective and did not give them the skills and knowledge to carry out their duties safely. For example, an online clip had been shown to increase their knowledge in using a piece of equipment, three staff told us this was not sufficient to give them the confidence and skills required.
- The system to monitor and ensure staff training was up to date was not always effective. Some training needs had been identified but timely action had not been taken to meet these needs
- Staff received induction training in line with the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.

Adapting service, design, decoration to meet people's needs

- The provider and manager had made some recent changes to the environment to make it more homely and improve the facilities. For example, a garden building was recently added to be used as an activity room and a reminisce wall in the communal areas. However, further work was required. For example, the garden included a smoking area and cigarettes were seen on the floor which did not make it an appealing space for people to access.
- There was signage around the building and photographs on people's doors to help people living with dementia to orientate around the building, however further consideration was needed. For example, the use of colour contrast and a quieter space for people to spend time in. We recommended the provider consider best practice guidance in relation to adapting the environment further to meet people's needs.

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 when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

● We found one person's care plan contained guidance for staff to use a restraint to support someone if they continued to refuse personal care. There was no evidence that this was proportionate to the person's needs and the least restrictive way to support the person. Although staff confirmed restraint had never been used, its inclusion in the person's care plan increased the risk of restrictive practice.
● At the last inspection some staff lacked the knowledge about whether people had authorised DoLs in place. This was still a concern at this inspection, however staff were able to explain how they would support someone in the least restrictive way, and were clear about who was able to make their own decisions and how they would respect this.
● We found DoLS applications had been submitted to the local authority as required by law to deprive people of their liberty in order to protect their health and wellbeing. However, the manager had not updated the local authority when there were changes in people's behaviours which increased the risk around their restrictions.
● Where people had the legal authority to make decisions on behalf of their relative the provider had ensured they had the evidence to confirm this.

Supporting people to eat and drink enough to maintain a balanced diet
● At the last inspection concerns had been identified in relation to the food provided and mealtime experience. At this inspection we found improvements had been made. Most people were positive about the food. One person told us, "The food is actually very nice and there is plenty of choice." Another said, "We have lots of food and it is very nice. They give us a choice...and if you don't like it then there is always an alternative."
● We observed lunchtime as a calm and pleasant environment. People were shown plates of food in order to make a choice and tables were laid with table clothes and condiments available.
● There was a 'snack' station where people could help themselves to cold drinks and snacks such as fruit, crisps and cakes.
● People had been asked about the food in the service at a recent 'resident's meeting'. Someone had asked for a specific cultural food and the manager advised they were following this up. We also saw other cultural options were available for people.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People told us they had access to health care professionals when required. One person told us, "The chiropodist has come and the doctors come."
● When Healthwatch visited in January 2020 there had been concerns raised about one person's access to the dentist. We saw this had been addressed and saw people had been visited by the dentist.
● One health care professional told us they had seen improvements in the service since they had been visiting.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not consistently promoted. One person told us, "I am not allowed to use the toilet as they haven't got the right equipment for me. I have been instructed to use pads which is both difficult and degrading for me." We found the equipment was available but staff were not using it as they needed further training. This training had not been provided in a timely manner and as a result the person's dignity had been compromised. We raised this with the manager and this had been addressed by the second day of inspection.
- The service had not considered if anyone could be independent with their medicines and this had not been offered.
- There were mixed views about whether people were supported to maintain their independence. One person told us, "Yes, they encourage my independence," whilst a relative and healthcare professional felt more could be done to maintain people's independence and keep people active.
- People's privacy was respected. Staff explained how they respected people's privacy by knocking on people's doors before entering and ensuring the curtains were closed.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staff were caring. One person said, "They are all very kind and thoughtful." Another person told us, "I like the staff, no one is ever rude or sharp, they look after everyone very well."
- We saw kind and respectful interactions between people. Staff took time to talk and interact with people, one person was supported to engage with a therapeutic doll which helped them to become less agitated.

Supporting people to express their views and be involved in making decisions about their care

- At the last inspection we found people were not always involved in making decisions about their care and support. At this inspection we saw improvements had been made and records showed people and relatives were involved in reviews.
- People told us they knew about their care plan and were asked about their care. One person told us, "Yes I have seen my care plan, the manager comes up to see me. Another said, "I have a care plan as well as my own care worker link. We had a resident's meeting and I asked about going to church, they assured me this can be arranged, so I do think they listen."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection the provider had failed to ensure care was personalised and able to meet people's needs effectively. This was a breach of regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9. However, there were still improvements required to the responsiveness of the service.

● At our last inspection we found a lack of leisure opportunities were provided and people were saying they were bored and had nothing to do. At this inspection we found improvements had been made but some people and staff felt further improvements could be made. One person who had been at the service for a short period of time said, "I haven't seen any activities since I have been here, except for today." A staff member told us, "There is not always enough staff, not enough time."
● There were mixed views about the provision of person-centred care and responsiveness of staff. One person told us, "I can't get up or go to bed when I want as I have to wait." Another said, "I like a cup of tea at 5am and they always get me one. I can get up and go to bed when I want." We found one person's dignity had been affected as staff had not responded in a timely way to their need.
● We observed different activities being carried out, for example games, people enjoying an external entertainer who came in, knitting and going out for a pub meal. An activities newsletter had been produced for the month of January which had photos of the activities carried out.
● We saw improvements had been made to ensure people's religious needs were met. One person had a regular visitor from their church and staff supported someone else to read the bible. A person told us, "I have asked about going to church once a month…they have assured me this can be arranged."
● Since our last inspection, the registered manager had been working on improving care plans to ensure they were more personalised. Staff had knowledge of people's personal preferences and backgrounds and told us how they supported people in a person-centred way using this knowledge. For example, staff explained how they supported someone to listen to particular music from their own culture.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability,

impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were identified in their care plans.
● We observed people being shown the food on the plates at mealtimes in order to make an immediate choice.
● The complaints procedure was produced in an easy read guide, and pictures and photos were on display to show options for activities and menu choices.

Improving care quality in response to complaints or concerns
● The provider had a complaints process in place, so people could share their views. This was on display in the reception area of the service.
● People and relatives told us they would feel comfortable to raise concerns.

End of life care and support
● People and their relatives were asked about people's individual wishes regarding end of life care and this was recorded in their care plans. The manager shared a new document with us that she was planning to put in place to make further improvements in this area.

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 Inadequate. At this inspection this key question has remained the same. 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; Continuous learning and improving care

At our last inspection there were insufficient and inadequate systems in place to monitor and improve the quality of the service. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements although they still failed to meet the requirements of the law.

- There were inadequate systems in place to ensure risks to people were adequately assessed, monitored and reviewed. As a result, people were not protected from risks associated with constipation, dehydration, moving and handling and distressed behaviour.
- There were ineffective systems in place to monitor accidents and incidents. There was no oversight or systems in place to analyse information and use lessons learnt to reduce the likelihood of re-occurrence.
- The provider had failed to ensure there was a culture of continuous learning in the service. Some concerns which had been highlighted at the last inspection had not been addressed, for example in relation to fluid intake and manual handling.
- Systems had failed to ensure assessments were in place for people who were at the service for a short time, or who came in an emergency. This increased the risk of the service being unable to meet people's needs and one person had been placed at risk of harm.
- The provider had failed to develop effective systems to assess staff competency in their roles and ensure training was effective. Whilst some competency checks were completed, this needed further development, for example to include manual handling competencies. Some staff reported feeling underconfident to carry out certain skills following training and found training wasn't always effective.
- The provider had not made sufficient improvements since our last inspection to drive forward the quality of the service. Systems to monitor the safety of the service were inadequate and had not ensured people received care and support as required.
- At the time of the inspection there was no registered manager in post as the previous manager had left in August 2019. There was a manager in place at the service and during the inspection we were told they had begun the process of applying to become the registered manager.

The provider's failure to ensure that effective systems were in place was a continuing breach of a Regulation

17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good governance.

● We found improvements since the last inspection in the monitoring of pressure areas, oral care and medicines.
● The area manager shared with us a document they were putting into place to assess staff competencies for manual handling.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Although there had been some improvements to ensure people received person-centred care, there were still some concerns that care was not always provided in a dignified way.
● Most people knew who the manager was and spoke highly of them. One person told us, "The manager is really good and she talks to everyone." Another said, "The manager is very good, excellent in fact. She tries so hard to make it like home for me."
● We found improvements had been made since the last inspection to involve people and their relatives in reviewing their care.

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 management team were open and transparent during the inspection and demonstrated a willingness to listen and improve. This was demonstrated by the action they took in response to our feedback during the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Some staff didn't feel their work was recognised by management and individual concerns about staff were not always addressed appropriately.
● Staff told us they attended team meetings were held and the management was approachable if they had concerns about people. There was an employee of the month scheme to recognise good practice.
● Improvements were being made to involving people in the service and a recent 'relatives' and 'residents' meeting had taken place. In these meetings discussions were held and views encouraged about activities, food, staff, the decoration of the home and communication.

Working in partnership with others
● The manager was working with the local authority quality team to improve the care and safety within the service and we identified some improvements in the areas of concern highlighted at the last inspection.
● The service worked in partnership with other professionals and agencies, such as community health services and social workers to ensure that people received the care and support they needed. One professional told us, "The service has got better, there are more activities, more interaction with residents."