Advinia Care Homes Limited

Stonedale Lodge Care Home

Inspection report

200 Stonedale Crescent
Liverpool
Merseyside
L11 9DJ

Tel: 01515492020

Date of inspection visit:
29 September 2020

Date of publication:
13 October 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stonedale Lodge Care Home is a residential care and nursing home in the Croxteth area of Liverpool, providing personal and nursing care to 141 people aged 65 and over at the time of the inspection. The service can support up to 180 people across six units, each specialising in either residential or nursing care for older people, including those living with dementia.

People's experience of using this service and what we found
When we inspected Stonedale Lodge Care Home to assess the safety and quality of people's care, we took into consideration the significant pressures the COVID-19 pandemic had put on this service in particular. We also considered what people, relatives and staff told us, as well as the information we found, regarding care provided across the six different units, to arrive at balanced and proportionate judgements for the service as whole.

It was clear that the service had had an unsettled period, with the outside pressures of the COVID-19 pandemic adding to internal difficulties. The provider had addressed this, and the service was receiving ongoing support, including from the provider's regional team. Detailed improvement plans were in place to help achieve progress. Staff and the provider were honest that there had been improvements, but there was more work to be done, to recover and provide consistently good care for people and support for staff.

We highlighted particular areas for improvement, to achieve greater safety and consistency, and have made recommendations regarding risk management and records, staffing and quality assurance. We have also signposted the provider to resources to develop their infection prevention and control approaches, including updating audits and working closely with local specialist teams. The service had addressed the issues from the last inspection, however we found medicines were not always managed safely across the home.

However, there were also particularly positive aspects, such as continued staff dedication to people using the service during the pandemic and on balance encouraging feedback from people, relatives and staff. When people had needed to be isolated on their unit to prevent the risk from further spreading of COVID-19 infection, staff had "moved into" the unit with them. People felt safe living at Stonedale Lodge Care Home, spoke well of the staff and told us, "[The staff are] first class, I get on well with them" and "Staff are lovely, they do anything for me, I get spoilt."

We had received some concerns from relatives prior to inspection, which the provider was addressing. However, relatives we spoke with during the inspection gave very positive feedback about the service. They felt their loved ones were safe living at Stonedale Lodge Care Home, describing it as a "home from home", and one said, "The home was recommended to me and I have never regretted the decision. They have made everything so easy."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update)
The rating following the last comprehensive inspection for this service was requires improvement (published 25 June 2019). We also published a report following a targeted inspection, which did not change the rating for the service (published 5 December 2019).

At the last comprehensive inspection, we found a breach of regulations regarding good governance. The provider completed an action plan after the last comprehensive inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made and the provider was no longer in breach of regulations; however, we made recommendations for the provider to make further improvements or maintain progress.

Why we inspected
Based on the service's previous rating of requires improvement and the breach of regulation we found at the last inspection, 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 remained requires improvement. This is based on the findings at this inspection. This is the third consecutive time the service has been rated as requires improvement.

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 Stonedale Lodge Care Home on our website at www.cqc.org.uk.

Enforcement:
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering if enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-led findings below.	**Requires Improvement**

Stonedale Lodge 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.

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 two inspectors, an assistant inspector, two medicines 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
Stonedale Lodge 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 still had a manager registered with the Care Quality Commission, although they had left the provider's employment. 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. We confirmed with the provider that they were addressing the previous manager's remaining registration.

Notice of inspection
We gave the service a short notice of the inspection. This was because we needed the service to safely support our visit with respect to any identified infection risks. We also needed the service to arrange for us to have telephone conversations with residents' relatives and friends, while they were not able to visit the service.

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, professionals who work with the service and 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. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection-
We visited five out of the service's six units, with the sixth unit noted as being in 'lockdown' at the time of our visit, to control any potential risk of spreading infection. We spoke with 14 people who used the service and lived on different units. We carried out a 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 spoke with ten relatives on the telephone, to ask about their experience of the care provided. We spoke with 22 members of staff working in different parts of the service, including the service's head of care and deputy manager, as well as the provider's regional director and the quality and compliance manager for the North. This included calling staff on the telephone after we had visited the service.

We reviewed a range of records. This included people's care and medication records. We looked at files in relation to staffing, recruitment and the management of the service, including quality and safety checks.

After the inspection
After we visited the service we reviewed further care, safety and quality records we had asked the registered manager to send to us to look at remotely. We continued to seek clarification from the provider to validate evidence found.

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 comprehensive 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; Systems and processes to safeguard people from the risk of abuse

- Assessments of risks to people's individual health and safety had been completed and were, on balance, reviewed regularly, but at times needed greater consistency in completion and accuracy.
- Information in care plans relating to people's individual risk assessments included person-centred details. At times this needed to be clearer and more consistent to guide all staff, including those who might be covering shifts on different units and therefore did not know people well. Staff told us that key information about people's safety was communicated during handover meetings.
- Recommendations following safeguarding investigations had identified that information and communication regarding people's risks needed to be improved. The provider had effectively identified areas for improvement and there had been progress. However, at times this needed to be achieved more robustly and quickly, including the development of some missing care plans.

We recommend the provider continues to review the quality and consistency of information in people's care records and implements identified improvements with speed.

- People told us they felt safe living at Stonedale Lodge and were supportive of the staff. People's comments included, "Overall, the [staff] are brilliant. I need a stand aid, and they know how to use it" and "I feel safe, staff help me as I do not have much grip in my hands."
- The service was aware of some family members' concerns regarding their relatives' care and these were being investigated. However, all of the relatives we spoke with during our inspection commented very positively about the safety of people's care. One commented, "[Relative] had [pressure] ulcers when they came out of hospital and with the care at the home they have been sorted out. Their weight is being maintained and if staff had any concerns then they would ring me straight away."
- Staff had not always felt listened to but those we spoke with had more confidence now that their concerns would be heard and acted on by the unit managers and deputy manager. Staff were confident to inform the local authority or CQC if they felt their concerns were not being addressed.
- Environmental checks were completed regularly. We identified some outstanding repairs, which the provider informed us had been completed following our visit.

Staffing and recruitment

- People's experience of staffing levels varied across the different units of the service. Most people we spoke with felt there were enough staff, but others told us at times they had to wait a long time to be helped.

People's comments included, "Not enough staff, is that all, only three [staff] working of a day. I press my alarm, sometimes they do not come as they say they are busy."
● Staff on some units felt there were enough staff, while others felt there were not always. We understood that the COVID-19 pandemic at times put pressures on the service, although the provider was continuously recruiting. Staff we spoke with felt there were enough staff to keep people safe. However, they noted pressures, such as needing to cover a unit where people may be at greater risk, at times meant there was less time for person-centred care on their own unit.
● Managers were reviewing people's individual care dependency assessments to clarify people's needs and help ensure they were met appropriately.

We recommend the provider reviews staff planning and deployment on completion of dependency reviews and consults with people and staff to understand, as well as support, their experiences.

● New staff had on balance been recruited using appropriate checks. However, we clarified with the provider the need to make some information accessible that had been stored on the previous manager's computer.

Using medicines safely
● Medicines were generally managed safely across the service. There were some issues found, but regular auditing and monitoring assured us that these would be actioned. The service used electronic records for managing medicines and records we checked showed people's medicines were administered properly.
● There was a lack of person-centred detail to guide staff when people required 'when required' medicines or when medicines were administered covertly, hidden in food or drink. These need to be improved.
● One person with end of life medicines prescribed, required review as the prescription was out of date, however the medicines were not required.
● Care staff did not always record when topical medicines were applied so we could not be sure they were applied as prescribed.

Preventing and controlling infection
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Learning lessons when things go wrong
● Managers completed an analysis of accidents and incidents, to help identify measures to prevent reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last comprehensive inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant that some aspects of service management did not always support the delivery of safe, 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 comprehensive inspection, the provider had failed to robustly monitor and improve the quality and safety of the service. Records about people were not always accurate, complete and contemporaneous. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that, on balance, the provider had identified issues and made progress, so that they were no longer in breach of the regulation. However, further improvements were needed and we will continue to monitor this closely.

- Auditing and management systems had identified issues, such as relating to the availability and accuracy of people's care records. This had led to improvements, but at times these needed to be achieved more quickly and effectively, for example when missing care plans had been identified. We highlighted that at times information and electronic care systems needed to be more easily accessible for those staff supporting different units.
- Regular managers' checks were carried out on the units, which had identified issues, but at times needed to address them more robustly. This included for example effective use of monitoring charts to support safe care for people. The service was receiving ongoing development support from the provider, including from the regional director and the regional quality and compliance manager.

We recommend the provider continues to review progress against service improvement plans, to ensure actions relating to people's safety are addressed quickly and effectively.

- The service still had a manager registered with CQC, however they had left the provider's employment. We clarified with the provider next steps to take regarding this. Recruitment for new service management was ongoing. The service was overseen by the deputy manager (head of care), together with unit managers and support from regional managers.

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

- Staff gave honest feedback about previous leadership arrangements and that they had not always felt

listened to or supported. There were still comments that showed more work was needed to promote staff confidence. The provider assured us things such as 'Human Resource clinics', where staff could voice concerns, would be continued.
● Staff on balance praised the teamwork at the service now and gave positive feedback about improvements and support provided by the deputy manager and unit managers ("managers"). Their comments included, "We support each other. I have learned a lot from [manager's name]. The residents are well looked after, we have a good rapport with the family, they let us know if they need anything else" and "[Manager's name] is amazing, very supportive, and has done really well under the circumstances."
● People spoke positively about the staff. Residents' meetings had been paused during the COVID-19 pandemic but were set to be restarted. People's comments included, "I feel safe and well looked after" and "[The staff are] first class, I get on with them well."
● We discussed previous mixed feedback from relatives with the provider. However, feedback from relatives we spoke with during the inspection was very positive. Relatives' comments included, "The unit manager looks after [relative] like a friend", "I am really happy that I moved my [relative] here" and "The home is a home from home." The provider shared examples of newsletters with us, to share information with people, relatives and staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff had shown particular dedication to people during difficult periods, especially the challenging times caused by the COVID-19 pandemic. When a unit needed to be 'locked down', to prevent the further spread of infection, staff had "moved into" the unit with people, to keep them safe.
● Staff spoke with care about people, putting people's individualities and best interests first in their conversations with us. We observed caring, person-centred interactions and on the day, we visited care was being delivered at a relaxed, unrushed pace.
● Level of person-centred detail varied in care plans, but they provided basic guidance for staff.

Working in partnership with others
● The service worked in partnership with external professionals. This included having regular meetings with local authority commissioners, clinical commissioners and community matrons. At these meetings progress of the service and any arising issues were discussed together.