HC-One Limited

# Stoneyford Care Home

## Inspection report

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Date of inspection visit:
18 October 2017
19 October 2017

Date of publication:
26 January 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| 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

The service is registered to provide accommodation with personal care for up to 60 older people with varying support needs, including nursing and people living with dementia. Accommodation for up to 60 people is provided at the service over two floors. There were 30 people using the service at the time of our inspection.

At our last inspection of the service on the 10 and 11 August 2016 the service was rated overall as 'Good'. However, some improvements in safety were required. Risks were not always managed so that people were protected from avoidable harm. Robust systems were not in place to ensure that sufficient staff were on duty to meet people's needs. Medicines management and infection control practices also required improvement.

At this inspection we found ongoing concerns of how risks associated to people's needs were assessed, planned for and reviewed. There were some continued shortfalls in the prevention and control of infections and medicine management. We also found further concerns which led to six breaches of the Health and Social Care Act 2008 Regulations (2014). You can see what action we told the provider to take at the back of the full version of the report.

A registered manager was in post and they were available during the inspection, they were currently being supported by a registered manager of another service within the organisation who was also present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People could not be assured appropriate and timely action was taken when there was an allegation or concerns of abuse or avoidable harm. Where people had a Deprivation of Liberty Safeguard authorisation with conditions that required the provider to action, these were found not to have been completed. The principles of the Mental Capacity Act 2005 were not always followed. Some inconsistencies were identified in how best interest decisions had been made.

Risks associated to people's healthcare needs had not always been appropriately assessed, planned for, monitored and reviewed. This impacted on people's safety and welfare.

The deployment of staff required further review to ensure there were sufficient staff available at all times to support people's safety, including oversight and accountability of clinical needs and risks.

Some issues were identified with the management of medicines in relation to storage and management. Action was being taken to improve audits and systems, oversight and accountability.

The checks and systems in place with regard to cleanliness and the prevention and control of infection control had improved but some shortfalls were identified.

People could not be assured their dietary and nutritional needs were consistently and effectively managed. Actions to follow external healthcare professional recommendations were not always acted upon or in a timely manner.

Improvements were required in how people's healthcare needs were met. Further action was needed to ensure the service worked with external healthcare professionals in a collaborative way to meet people's health needs and outcomes.

Staff received an induction, ongoing training and opportunities to review their work and development needs. Nurses employed to work at the service were appropriately registered with the Nursing and Midwifery Council. Staff had been recruited through safe recruitment procedures.

Some inconsistencies were identified in how staff provided a caring, kind and compassionate service. Whilst some positive staff engagement was observed, however people's dignity and respect were compromised at times.

There was no advocacy service information available for people if they required this support. People and their relatives did not receive formal opportunities to participate in a review of the care and treatment.

Information to support staff to provide care and treatment that was person centred and reflected people's needs and preferences lacked detail, guidance and support. People received limited opportunities to participate in meaningful activities that met their interest, hobbies and needs. We have made a recommendation about staff training on the subject of dementia.

People were aware of the complaint policy and procedure but the complaint's information was not presented in an appropriate format to meet the sensory needs of all people.

The provider had failed to report some significant events that occurred in the service to us at CQC a registration regulatory requirement.

Over reliance on external professionals to identify what action was needed to meet people's needs was identified, the provider had failed effectively to assess, mitigate risks and learn from past incidents and concerns. The service had shown limited progress of improvement in relation to how clinical risks were managed following regular feedback from quality monitoring visits completed by external agencies.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that provider's found to have been providing inadequate care should have made significant improvements within this timeframe.

## 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

People could not be assured appropriate and timely action was taken when there was an allegation or concerns of abuse or avoidable harm.

Risks associated with people's needs were not sufficiently assessed, monitored and managed.

The deployment of staff and clinical leadership required reviewing to ensure this was consistently effective at all times. Staff were employed appropriately with the necessary checks completed.

Some improvements were required with the management of medicines and the cleanliness of the service to support effective infection control practice.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective

The management of people's food intake and hydration required improved recording and monitoring. Recommendations made by external healthcare professionals were not always followed.

The principles of the Mental Capacity Act were not always followed, inconsistencies were found in how some best interest decisions were made. Deprivation of Liberty Safeguard conditions had not been acted upon to protect people.

Improvements were required with monitoring changes in people's healthcare needs to ensure these were acted upon quickly.

Staff received an induction and ongoing training and support.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring

There were inconsistencies in the approach of staff where dignity was not always respected.

Improvements were required in how people and their relatives were involved in their care and treatment.

People did not have information about independent advocacy support. People's sensory needs were not always met in a way that supported them to be as involved as fully as possible in their care.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive

There was a lack of information available to support staff to provide an effective and responsive service based on people's individual needs.

There were some activities available for people but these did not always meet the social needs or interests of people. There was a lack of stimulation and activities for people living with dementia.

People felt able to complain to staff if they had any concerns. The complaints policy was visible, but not provided in an appropriate format for all people who used the service.

## Is the service well-led?

**Inadequate**

The service was not well-led

Concerns were identified with leadership, in particular understanding clinical risks and management.

The provider had continued to fail to report significant events that occurred in the service to us at CQC

Whilst there were systems and processes in place to monitor quality and safety these were found to be ineffective.

# Stoneyford Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a coroner investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared about the incident indicated potential concerns about the management of the risk of choking. This inspection examined those risks.

This inspection took place on the 18 October 2017 and was unannounced. We returned to the service on the 19 October 2017 to complete the inspection.

The inspection team consisted of one inspector, a specialist advisor who was a pharmacist, a specialist advisor who was a registered nurse and two experts by experience. An expert by experience is a person who had personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. These included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service.

During the inspection visit we spoke with five people who used the service and nine visiting relatives. 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 spoke with the registered manager, supporting manager, the regional director, a nursing assistant, the residential unit manager, four care staff, one senior care staff, the cook, two housekeeping staff, and an

activity coordinator. We also spoke with two visiting external professionals, an occupational therapist and an advanced nurse practitioner and a tissue viability nurse on the telephone. To help us assess how people's care needs were being met we reviewed all or parts of the care records of 12 people along with other records relevant to the running of the service. These included policies and procedures, records of staff training, the management of medicines and records of quality assurance processes.

Inadequate

# Is the service safe?

## Our findings

At our last inspection we identified some concerns with how risks were managed. At this inspection we found continued concerns in relation to how risks associated with people's needs were assessed, planned for and monitored. Individual risk assessments were completed to assess people's risk of developing pressure ulcers, falls, nutrition and choking. However, we did not always see how this information linked between care plans. In some cases care plans contradicted the outcomes of the assessments. For example, a person's falls risk assessment indicated there were a considerable number of factors which placed them at high of falls. However, their safe environment care plan stated they were at low risk of falls but required bed rails to maintain their safety.

Some people at the service had been assessed as being at risk of choking. We found documentation in place such as eating and drinking care plans, choke risk assessments, and information to alert staff including kitchen staff, of how meals should be provided, such as a soft diet. Information included the recommendations and the support required by staff for individuals, made by external speech and language therapists who had completed swallowing assessments.

However, on the first day of our inspection visit we observed a person known to be at risk of choking to be alone in their bedroom in the morning eating a yogurt and alone in their bedroom at lunchtime eating their main meal. The registered manager confirmed this person was a choke risk and required supervision. Other people identified as being at risk of choking were observed to receive support as required. Before our inspection we received feedback from visiting healthcare professionals about two incidents they had witnessed where people known to be at risk of choking were not supervised when eating. This meant there had been three occasions between 19 September 2017 and 18 October 2017 where people known to be at risk of choking were observed to be eating alone without supervision. This significantly impacted on their safety.

We found from reviewing people's care records when risks were identified and external professionals provided advice or recommendations to reduce the risk, this was not always followed in a timely manner. For example, a person had bed rails in place for their safety, but had suffered some skin damage to their knees as they rubbed against the netting between the rails. The tissue viability nurse recommended the bed rails were changed or additional "bumpers" used to prevent this happening again. They told us the registered manager had ordered new bed sides but they were the wrong size and they said they would be returned and replaced. When we checked during the inspection, bed sides with netting were still being used. The registered manager told us they were still trying to source alternative bed sides but thought a bumper was in place that went over the netting to protect the person as a temporary measure. We found this was not the case when we checked and no date had been identified of when new bed sides would be in place.

On the second day of our inspection a visiting healthcare professional told us they had identified staff were using an inappropriate sling to support a person to transfer from their wheelchair to their bed which was unsafe. Staff said they had alternative slings that were being laundered. The occupational therapist advised the person remained on their bed until an appropriate sling was available. This was a concern because staff

had not identified they were putting the person at risk due to using an unsuitable sling.

Some people required re-positioning to prevent pressure ulcers. Two people's care records indicated they should be checked and repositioned every two to four hours. However records for one person we viewed for 16th October 2017 showed they had been checked every two to four hours but remained positioned on their back from 7.40am to 9.45pm. However two days prior to this other records showed the person had been repositioned in accordance to their care plan.

Before our inspection we were advised by external healthcare professionals there was ongoing concerns about how people's wound care was managed. It was acknowledged changes had recently been made with the implementation of new documentation and systems and improvements were ongoing.

We looked at the folder containing all the information about people's wound care. However, we found this was disorganised and some records were missing or misplaced. For example, we found a wound assessment chart labelled as belonging to one person in another person's section of the folder. Another wound assessment chart was found without any labelling as to the name of the person or the wound it referred to. There was no wound care plan in the folder for one person although there was a wound progress and assessment record and some entries when dressings were changed. Photographs of the wounds had been taken to enable assessment of wound healing however; they were not always labelled and filed in such a way as to enable comparisons to be made easily when people had more than one wound. A person's skin integrity care plan stated they had chronic leg ulcers which should be re-dressed alternate days, however, over the page, another part of the care plan stated they should be dressed daily. Both of the entries had been made over six months previously and therefore current requirements were unclear and we could not be assured the person was receiving the most appropriate treatment for their condition.

Before our inspection visit we were informed by an external professional of a person who they had identified during a visit, had not received their prescribed medicine for a four week period during August / September 2017, a medicine to treat mood and anxiety. After the first prescription the medicine administration record repeatedly recorded this medicine was 'out of stock'. This meant staff had disregarded the person's care and treatment, potentially impacting on their health and wellbeing .

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and visiting relatives considered the service to be safe. One person said, "I feel safe. Nothing goes wrong, but it can be a bit slow. I have lost nothing (possessions). The staff are very good. I have rails and padding on my bed to stop me falling out." A relative said, "If [family member] wasn't safe here, I would move them."

Staff were aware of the signs of abuse and told us they would report concerns to the registered manager. Records confirmed staff had received safeguarding training and they had a safeguarding policy and procedures available to support them. Staff told us they were aware of the whistleblowing policy and the telephone numbers were available within the service. A whistleblowing policy was found to be available. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Feedback received from external health and social care professionals and through discussion with the registered manager and reviewing care records, we identified not all safeguarding allegations had been reported or acted upon in a timely manner. The registered manager agreed they had not always taken the

required action.

We received a mixed response from people who used the service and visiting relatives about the staffing levels. Whilst some people felt there were sufficient staff others felt there was insufficient staff at busier times of the day. One person said, "Generally not a long wait. But can be longer in the mornings or it can be longer at busy time like lunch or evenings. Once or twice I have had to wait for more than 10 minutes. They could do with more staff at busy times." A relative said, "It varies, sometimes a little bit low on staff but on the whole its fine. It's when there are people off sick." Some relatives were concerned with the use of agency staff and felt they were not knowledgeable about their relative's needs.

Some staff felt there was insufficient staff in the nursing unit, saying the dependency needs of people impacted on staff's availability. Other staff said they felt when staffing numbers were correct and there was no sickness, it was sufficient. Staff were confident consideration was given to staff skill mix and experience. There was one nurse employed at the service, two nursing staff having very recently left. The service relied on agency staff to cover nursing vacancies whilst permanent nursing staff were recruited. The management team told us they tried to use one particular nursing agency and tried to book nurses familiar with the service to provide some continuity. The staff roster showed different agencies were used with one agency used more than others.

We spoke with the management team about who had the lead responsibility for nursing needs due to the absence of a lead nurse in this role. This was a particular concern due to the risks identified in meeting some clinical needs. The regional director told us and confirmed in writing following our inspection, what plans were in place to address this issue.

The regional director told us how they calculated the staffing numbers required based on people's dependency needs. Where people had been assessed and funded for additional staff support due to risks associated with their needs this was found to be in place.

We observed staff responded to people's requests for assistance in a timely manner. Whilst we found during our inspection the service had sufficient staffing levels, we spoke with the management team about the deployment of staff due to concerns identified. For example, three staff were seen to take their break at the same time, impacting on the availability of staff to be present at all times in communal areas as well as supporting people cared for in bed. The management team said they would review how staff were deployed to ensure it was maximised effectively at all time to ensure people's safety.

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included criminal records check and employment history. We checked nursing staff's registrations were in date with the Nursing and Midwifery Council to ensure they were registered to provide nursing care and found they were.

People who used the service and visiting relatives on the whole told us they felt prescribed medicines were administered safely. One person said, "They (staff) handle medicines very good. I haven't missed any to the best of my knowledge. I get them regular." A relative told us they had concerns about a particular medicine their family member had which ran out and an agency nurse who gave the wrong medicine but they [relative] "Spotted it in time"

Feedback from three external healthcare professionals also told us how in the recent past there had been concerns about medicines being out of stock, stored incorrectly or not administered correctly. We discussed these issues with the management team. Records confirmed one concern related to a medicines error that

had been identified and dealt with appropriately. One was subject to a safeguarding investigation and the third relating to out of stock medicines, action was being taken with how medicines were managed and monitored. We were assured by the management team this would reduce any errors and improve accountability.

During our inspection we observed the safe administration of people's medicines followed best practice guidance. The staff member stayed with the person to ensure they had taken their medicines safely and gave explanation of what the person's medicines were for. Staff had the required information about people's medicines including individual preferences of how they liked to take their medicines. Where people had prescribed medicines to be used 'as and when required' such as for pain relief or anxiety, information was provided to instruct staff how this should be administered. Records confirmed staff had received appropriate ongoing medicines training. Medication administration records we reviewed confirmed people had taken their prescribed medicines as instructed. We completed a sample stock check on medicines and found this to be correct.

Some issues were identified in the medicines documentation. For example, it was noted staff handwritten entries on the medicine administration records did not include the start date and end date of the medicine which is required. We observed that liquid medicines were not always labelled with their date of opening to ensure they were not administered past their expiration date.

We also observed that not all medicines had a clear start date recorded on the box/label as per the homes medicine policy guidance. Fridge and room temperatures were being recorded daily but not consistently. For example some records were missing on the following dates: 1 October 2017, 2 October 2017 and from 6 October till 15 October 2017. Temperature checks are important to ensure medicines are stored correctly as too high can cause medicines to not be effective.

We identified a concern in relation to the administration practice of one person's medicine. This was discussed with the management team who took action and following our inspection sent us information confirming the action that had been taken. Some people received their medicines covertly. This means disguised in food or drinks unknowingly. We saw examples of mental capacity assessments and best interest decisions were documented. However, it was unclear if pharmacy advice had been sought to ensure medicines given covertly were given appropriately as some medicine is unsuitable to be put into food or drinks. These issues were discussed with the management team who agreed to take immediate action to address these.

At our last inspection we identified some concerns with the cleanliness of the service. We were aware that the local Clinical Commissioning Group (CCG) completed an infection control audit in June 2017. A number of recommendations were made and the provider completed an action plan detailing the action they would make and by when. The CCG revisited the service again in October 2017 and found whilst there were some improvements the provider had not met their action plan targets. A further request was made for action to be taken to address these shortfalls.

At this inspection we found some of the carpets in the communal areas were stained or soiled. The management team told us a refurbishment programme was planned and also that new equipment for shampooing carpets and steam cleaning was being purchased. A cleaning schedule was in place and signed by the housekeeping staff to indicate which rooms were cleaned on a daily basis. However, we found gaps in the record indicating that on some days, some bedrooms and some communal areas were not cleaned. The regional director told us that it had been identified within the organisation that improvements around cleaning tasks and the documentation used to record cleaning was in the process of being reviewed. They

added that domestic staff would be receiving further training and support in this area.

Requires Improvement

# Is the service effective?

## Our findings

We asked the registered manager if people had an authorisation of a Deprivation of Liberty Safeguard (DoLS) with conditions. The registered manager was unable to initially provide this information. They advised this information had been sent from the supervisory body via email in September 2017 which they had been read. When we were given this information two people had been granted an authorisation to restrict them of their freedom and liberty and both had conditions the provider was required to act on. We noted that the DoLS assessments were completed in July 2017 and both people had been granted standard authorisations for twelve weeks. The registered manager took full responsibility for their oversight and action was taken to address the actions required. However, whilst both people were not being unlawfully restricted of their freedom and liberty, there was a significant delay in acting upon the DoLS authorisation conditions possibly impacting on people's health and welfare

All of the above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always effectively supported with their hydration and food intake. Records we reviewed indicated people were losing weight. From our observations we felt staff were not maximising the opportunities to increase some people's nutritional intake. There could have been more consideration of individual people's circumstances and preferences that may have resulted in an increased nutritional intake. For example, on the first day of our inspection we noted a number of people on the first floor were awake but had not had their breakfast at 9.45am. We spoke with one person who told us they were hungry. When we raised this to the member of staff allocated to serve breakfasts, they said they were "just starting to bring breakfasts round." We noted the person we spoke with was assisted with their breakfast at approximately 10am. Their eating and drinking care plan stated they required assistance, had a small appetite and had been losing weight. However, the staff assisting the person was in the room for a maximum of five minutes and they told us afterwards the person had eaten less than half of the porridge although they said the person really enjoyed porridge.

In addition, this person's medicine administration records stated the person was prescribed nutritional supplements as required. Their eating and drinking care plan stated they were prescribed supplements twice a day and they enjoyed the supplements. However, records showed only one nutritional supplement was given each day and this was given each morning immediately after breakfast when the person had eaten and was less likely to consume it. There was a period between 5.30pm and around 9.45am each day when the person's food chart indicated they had not had anything to eat. Providing the supplements and meals/snacks spaced more regularly throughout the day may have increased their consumption.

A visiting relative said, "[Name of family member] does eat well, but they were too tired to eat their breakfast this morning." The person's nutrition and fluid booklet was on the table beside them which the relative read and shared with us. There was an entry at 9.15am which recorded the person had not eaten their breakfast as they were too tired, so to try later. However, it was 11.49am, almost lunchtime, and no one had offered the person anything more to eat. The person was unable due to their communication needs to tell us if they

were hungry or not.

Another person had difficulties in swallowing and was receiving percutaneous endoscopic gastrostomy (PEG) this means their food was administered via a tube directly into their stomach. This procedure was used to supplement their oral intake. Records showed this person sometimes refused food or their PEG nutrition. They were seen by a dietician in August 2017 and the dietician identified they had lost weight and staff had highlighted they were less likely to refuse their PEG, if it was provided by staff they were familiar with. This was not recorded in the person's care plan and had not been implemented. The letter from the dietician received in September 2017 stated if the person continued to lose weight a more energy rich regime could be considered. Records showed the person continued to lose weight but this had not been reported to the dietician. This meant this person was not receiving the correct feeding regime they required.

When people were receiving PEG nutrition, records of administering this were not consistently completed. One person's care records advised they were having all their nutrition and fluids via a PEG tube. The dietician's feeding regime stated this person should have a total of 1500mls via the PEG daily. Record keeping in relation to their PEG intake was not consistently recorded suggesting the person was not correctly receiving the recommended amount. For example, on 15 October 2017 their fluid intake was 950mls (including the feed), on 16 October 2017 their intake was 1360mls, on 17 October 2017 it was recorded the person received 500mls of feed only with no entry for fluids. This meant this person was not receiving the correct feeding regime they required.

All of the above information was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and visiting relatives told us access to external healthcare professionals and services were organised when required. Feedback from external healthcare professionals was consistently negative about staff not making timely referrals when people's healthcare needs changed, not being kept up to date about people's healthcare needs and staff not always following recommendations made by them.

We found examples in people's care records that supported what external healthcare professionals told us. For example, an external healthcare professional had recorded in one person's care records, action was required by nursing staff to take a swab (a specimen was required using a particular material). However, it is reported to have been over 5 days before the service identified they did not have any equipment to take a swab. In another person's review meeting record it stated, "Reviewing Officer" (external professional) discussed a review by a speech and language therapist was required and it was agreed the service would re-refer the person. However, there was no indication anywhere in the care file that this had been done as requested. A third person's care records stated in May 2017 they were to be referred to the GP and to the speech and language therapist as they were refusing thickened fluids. However, we did not see any record to indicate this had happened or the outcome.

All of the above information was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and visiting relatives about the meals and drinks offered. People were positive about the choice available. One person said, "The food's very nice." Another person said, "We have a cup of tea in the afternoon and the morning. I'm diabetic so they (staff) give me diabetic biscuits." Visiting relatives were positive about the menu provided with one relative saying. "I've been here for lunch and it's good."

Kitchen staff showed us information they had in the kitchen about people's needs based on their nutritional,

dietary needs, risks and preferences. Food stocks were checked and found to be stored correctly. The last food hygiene inspection completed by the local authority was January 2017 and the service was rated 'Five Stars' the highest rating that can be received.

We found people's meal time experience on the whole was positive, relaxed and calm but noted the second day staff were better organised and staff were attentive to people's individual needs.

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.

Where people lacked mental capacity to make specific decisions in relation to the use of bed rails, or agreeing to their medicines, we found examples of MCA assessments and best interest decisions completed. However, there were inconsistencies in how these were completed, it was not always recorded who had been involved in best interest decisions and that least restrictive practice had been considered. For example, a person had a MCA assessment in relation to eating and drinking. Their care plan stated they required their fluids thickened to prevent choking but they were not happy with this. However, the best interest decision did not contain any reference to the use of thickened fluids. This meant that full consideration of the person's needs and wishes was not considered.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Where concerns had been identified about possible restrictions on people's freedom and liberty applications had been submitted to the supervisory body for assessment.

We saw examples of people signing some documents where they had given consent to certain areas of their care such as having their photograph taken. We saw some care records for people who had a decision not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Where people had lasting power of attorney that gave another person legal authority to make decisions on their behalf or if an advanced decision had been made, this information was recorded and staff informed. This meant that people's wishes were known, decisions planned for and staff had access to this information.

People who used the service and visiting relatives did not raise any concerns about issues relating to consent. We observed staff on the whole gained people's consent before providing care and treatment. However, some staff were observed to not always give people a choice. For example, we observed staff on several occasions moving people to different areas of the service but offered people no explanation or choice about this decision.

We observed a member of staff manoeuvring a person in a large wheelchair to a different position. As the staff member moved the person they caught the person's foot on the leg of a small table, the person called out in pain. The staff member apologised and pulled them back only to catch their foot twice more on the table leg before the person was in position. Each time the person called out in pain. The staff training record confirmed staff had received training in moving and handling, however we could not be assured all staff were competent in this area.

Overall care staff were found to be knowledgeable about people's care needs. A nursing assistant said they were concerned with the lack of permanent nursing staff and that they felt under pressure. They added they

felt there was an expectation by the management team for them to be able to respond to all clinical needs, which they felt unqualified to do as they were not a registered nurse.

People who used the service and visiting relatives repeatedly said they felt experienced staff supported those who were still developing the skills necessary to look after them effectively. One person said, "Some (staff) are knowledgeable, they're all very helpful, but others aren't. They do a good job." A relative said they did not think staff were sufficiently trained or skilled to support their family member's mobility needs effectively.

All staff referred to the supporting manager that visited the service weekly saying they were very knowledgeable and skilled and had made some positive changes that supported the staff. The registered manager was on the whole reported to be supportive and approachable. Staff were positive about the training opportunities. One staff member said, "Training is good and ongoing all the time." The majority of staff said they received opportunities to discuss their work and training and development needs.

Records confirmed staff received an appropriate induction and ongoing training and support. As part of the provider's induction staff were required to complete the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to. This told us that staff received a detailed induction programme that promoted good practice and was supportive to staff. Training records showed that staff attended a wide range of training which to meet the needs of people in their care.

Requires Improvement

# Is the service caring?

## Our findings

People who used the service and visiting relatives on the whole were positive and complementary about the staff. They described staff as caring and thoughtful. One person said, "Staff do all sorts of bits and bobs for me. They come on the red button (call bell) within minutes. They lift my shoulder and turn me on my side. They make a fuss. Sometimes if they they're not busy they will come and have a talk." Another person said, "They (the staff) always come in with a smile and it cheers me up." A relative said, "Some staff are very conscientious and caring. For some it's a job. A small number are disruptive and complain a lot of the time to each other. The service is trying to make improvements." Another relative said, "They (staff) talk kindly to [family member], like they care. Nothing's too much trouble. We haven't seen one that's not smiling while we've been here they've been pleasant and kind."

However one person's relative showed us their family member's finger nails which were badly soiled and a photograph they had taken the previous week showing similar soiled nails. They said they had discussed this with registered manager and the previous manager several times. They had also asked staff to ensure their family member's nails were cleaned when personal hygiene was provided. They had provided a nail brush to aid with this. However they said it continued to be a problem.

Our observations of staff interacting with people found them to be caring and attentive to people's needs but this was not always consistent. For example, a person was observed to be distressed and heard to say, "I'm scared." A staff member who was going off duty approached them and put their arm around the person in a comforting manner and directed them to a chair to sit down. A second staff member picked up on the situation and provided additional comfort and reassurance. They gained eye contact and addressed the person by their name, they listened to what the person said and talked to them quietly, and reassured them they were safe and all was well. The person responded positively and relaxed. A member of staff was seen to meet a person's comfort needs by giving them a blanket as they relaxed on the sofa.

However on the first floor of the service several of the people called for staff or repeatedly shouted, "Help me, help me." Staff appeared not to notice and did not respond except very occasionally. When a person who we had not heard calling previously, woke up and was disorientated and repeatedly called for staff at lunch time the request for assistance was not responded to. This was despite staff being nearby serving lunches so could clearly hear this person's distress.

We observed when staff had time to spend with people this was not always used effectively. For example, we observed a member of staff on two separate occasions standing in the lounge area with their hands in his pockets looking out of the window. On both occasions, when they noticed us they quickly took their hands out and moved towards people seated in the area they were in.

At lunchtime people were offered a choice from two plated meals. This was supportive and helpful in particular for people living with dementia to support them to make an informed choice. However, we saw a member of staff who initially offered people the two plated meals but when a person chose one of the meals; they did not replace it so other people they were serving had a visual choices. They continued serving

offering people a verbal choice only. Whilst the initial intention to support people with choices and decisions was good, this fell short due to the lack of attention and thoughtfulness by the staff member.

We observed some positive interactions by staff when they were supporting people with their meals and drinks. This included being patient, encouraging people to eat, and explaining what people were eating and chatting to people asking how they were. However, we observed a member of staff supporting a person to eat their meal whilst sitting at the table with other people who used the service. We knew the person they were supporting had some sensory needs that affected their communication. We observed the staff member engage with other people around them but did not with the person they were supporting. Several times during this support the member of staff got up and left the table to assist others but never explained to the person they were supporting. Whist it was felt the staff member was not deliberately being unkind, it was disrespectful.

Some people were living with dementia and were observed at times to become anxious and agitated affecting their mood and behaviour. We observed one person communicating their frustration and distress through their behaviour, which was challenging for staff to manage. Instead of staff managing the person's behaviour discreetly and sensitively, they were seen to raise their eyebrows in a disapproving manner and spoke to other staff across the room about the person and in front of others. This showed a lack of empathy and was disrespectful.

We saw an incident where a person was found sitting on the floor near the chair they were sitting on seconds before. Whilst this was an unexpected event and staff were concerned about the person, there was a lack of organisation and appropriate response. No action was taken to move other people from the incident or to shield the person to provide some privacy. Whilst one staff member took the person's pulse no other visible checks were carried out before the person was hoisted and moved away. We later saw this person was made comfortable in the lounge on a recliner chair.

We asked people if they felt involved in discussions and decisions about their care and treatment. One person said, "I do talk with staff about my care. I don't know about my care plan. My eyesight is not good. I have glasses but can't read with them." One relative said they were not aware of their family member's care plan and another relative said it was kept in the office and they were not involved in any review meetings. Another relative however, was fully aware of their family members care plan and told us they were invited to attend annual meetings to discuss the care and treatment provided to their family member.

The registered manager told us they were aware the opportunity for people and their relatives to have a formal meeting discuss their care and treatment was an area that required improvement. We found no information on display for people to advise them of any independent advocacy services should they have required this support. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. The registered manager told us there was no person who used the service that was currently being supported by an advocate.

People felt they were supported to be as independent as possible. One person said how they used adapted cutlery and crockery to support their independence with eating and drinking.

On the whole we received positive comments from people about how staff were respectful towards them. One person said, "I am always treated with respect. Staff always knock on the door. When washing me they pull the curtains shut." A relative said, "When we come to visit the staff will ask us to wait outside if they need to clean [family member]. We can hear from outside that they speak politely with them and are treating them with respect."

Staff gave examples of how they supported people whilst respecting their dignity and privacy. Staff told us they would close the door and curtains when providing care to preserve people's privacy and dignity.

However, we observed a staff member asking another staff member about a person who had just been admitted to the service in front of the person. When the other member of staff said they did not know the answer to a question, the person gave the member of staff the information. The member of staff did not apologise or acknowledge that they should have spoken to the person directly.

People told us their relatives were able to visit them whenever they wanted to. We saw relatives visiting people throughout the inspection visit. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

On the whole we found people's information was respected, for example it was managed and stored securely and appropriately. However, we observed one person sat in an upstairs lounge area alone sleeping. Beside them on the windowsill was a care plan and folder for another person. These were easily accessible to anyone passing.

Requires Improvement

# Is the service responsive?

## Our findings

Before people moved to Stoneyford Care Home they had an assessment of their needs completed and an initial seven day care plan to inform staff of their care requirements. Detailed care plans were then developed. However, a reoccurring concern raised by external healthcare professionals was that whilst care plans were evaluated monthly the care plan was not updated to clearly instruct staff what the person's current needs were. We found care plans lacked specific detailed information to support staff to consistently provide people with a responsive service based on their individual needs, wishes and preferences.

We found a number of people living with dementia experienced frequent periods of high anxiety affecting their mood and behaviour. From the care records we reviewed we did not see that staff had available information to provide effective and responsive care and support when people became anxious or agitated. Whilst some staff could explain what action they took to support a person during these times, the absence of any detailed written guidance meant there was a risk of inconsistent care and support.

One person's care records stated, 'can get agitated'. There was no further information of what this meant for the person, such as what potential triggers may affect the person's behaviour. Nor were there any behavioural strategies available to inform staff of the action required to reduce and manage periods of agitation. Records known as Antecedent, Behaviour, and Consequence (ABC) were used to record incidents when the person displayed behaviours. These records showed the person experienced frequent periods of distress that resulted in them shouting, biting, hitting and spitting at staff. Records indicated times of personal care were a possible trigger. However, this person's personal care plan did not inform staff of how to provide care and support at a time that may cause less distress for the person. Other people's care records with similar needs were found to also show a significant lack of information for staff of the actions required to support individuals effectively.

We asked the registered manager if the ABC records were reviewed and analysed to identify triggers, themes and patterns and if this was then used to inform staff of strategies to use. The registered manager told us they thought nursing staff reviewed them but there was no evidence of this. On viewing ABC records staff frequently recorded under 'consequence' 'I told (name of person) to stop (behaviour) this it's unacceptable.' This showed a lack of understanding and empathy into the needs of a person living with dementia and experiencing high anxiety and agitation.

On the first day of our inspection we met a person in their bedroom at 10am and left the bedroom within five minutes. This person was in their bed and appeared sleepy. Upon looking at the person's daily personal care records kept in their bedroom, it stated that no personal care had been provided since the previous day, other than re-positioning during the night as per their pressure care management plan. This person's care records stated they preferred to have a daily shave and that they wore glasses. At 10.20am the person was observed to have been from their bedroom to the dining room. They appeared to be wearing the same clothes and were not wearing their glasses. Upon checking the person's care records again they remained blank. We noted that an ABC record had been completed that stated when the person was supported to get up at 10.10am they displayed behaviours that included shouting and hitting out. We raised concerns with

the supporting manager of the time taken to support this person with their morning routine, which may have been a contributing factor to their agitation and behaviour. We were told night staff had provided personal care and supported the person to return to bed. In the event of no records to confirm this, we were not sufficiently assured this person had been supported with any personal care. This person was supported to wear their glasses after we had raised this with the supporting manager.

Before our inspection an external healthcare professional told us they had repeatedly asked for a person to have their moving and handling care plan and risk assessment updated. In March 2017 this person experienced a fall that affected their support needs. In June 2017 care records reported an improvement in the person's fall recovery affecting the support they required. Whilst the care plan had been evaluated monthly the care plan and risk assessment had not been updated to reflect the person's current needs. The external professional's last request for these records to be reviewed and amended was in October 2017. At our inspection we found this person's moving and handling care plan, including risk assessment had not been updated. We raised this with the supporting manager and the care records were updated as requested.

Another person had sensory needs; they were registered blind and had a hearing impairment. This person had a communication care plan that informed staff they chose not to wear their hearing aid or glasses. Information also advised this person was quietly spoken and what their preferred name was. A care record entry dated 2 October 2017 identified a care review was required. However, there was no further record to show this had been arranged and what support the person would require with their sensory needs to enable them to participate. This person's care records did not show any consideration had been made as to how they should receive information that met their sensory needs. Whilst the registered manager advised us they were aware of meeting the assessable information standard, they had not taken any action to fully address this and provide appropriate information for the person. The Accessible Information Standard means providers have a responsibility of how they meet the information or communication needs, relating to a person's disability, impairment or sensory loss. The person may have benefited from information being presented in alternative formats such as large print, braille or audio.

An external healthcare professional told us they had repeatedly discussed with the management team some concerns relating to a person's moving and handling needs. This person's relative told us they had concerns about the skill of some staff with their family member's mobility needs. They said, "Certain ones (staff) can't manoeuvre them in the lift so if they're the ones on duty they can't bring them down." We discussed this with the registered manager and whilst they told us of the action they were taking to address this issue, this was due to the perseverance of the external healthcare professional and should have been identified internally by the service and acted upon sooner.

All of the above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they had a choice of when to go to bed and to get up. Relatives told us there had been a change in the staff team recently and some were concerned about the loss of some staff they felt understood and knew their family member well.

Staff showed an awareness of people's diverse needs such as their religious and cultural needs or preferences. We observed a visiting minister was conducting a religious service, this included singing hymns and bible readings. The words for hymns were printed on sheets. However, these were not modified with larger print, coloured papers or Braille, for those with sensory needs.

The service had two activity coordinators whose role was to organise activities. People who used the service and visiting relatives told us the variety of activities was limited. One person said, 'I just sit around. There's nothing to do here. I like sewing and knitting but not here. I've been out once, we went to Skeggy (Skegness)."A relative said "[Family member] can't see so there's little they can do with them. They (staff) put music on sometimes and they'll join in the old songs. They were doing sticking on butterflies, but they couldn't do that."

People who were cared for in bed and visiting relatives of people with nursing needs in particular told us there were few activities they could participate in. Whilst there was a weekly activity plan to inform people what activities were available such as one to one sessions, church service, hairdressing and sessions labelled 'residents requests' there were days with no activities. Whilst there were some items of memorabilia around the service we did not see people using this or staff supporting people to explore these or to reminisce about pastimes gone. People were observed for long periods sitting without any meaningful activities. During our inspection we observed an art and craft group that required people to be able to hold a pencil or paper. Three of the eight people involved were observed to struggle to do this. As a result we found the range of activities on offer for people at the service did not always meet their needs.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia with regard to appropriate activities and opportunities.

People who used the service and visiting relatives told us they felt they could and would approach staff if they had concerns. People confirmed they were aware of the complaints information and this was available to therm. We noted the complaints procedure was not provided in different formats to support people's sensory and communication needs.

Staff were aware of their role and responsibility in responding to concerns and complaints. We reviewed the complaints log and found that all complaints had been responded to in a timely manner and in accordance to the complaint procedure having been thoroughly investigated and resolved.

Inadequate

# Is the service well-led?

## Our findings

At this inspection we identified concerns with the leadership of the service and with the lack of improvements in response to concerns we identified at the last comprehensive inspection in August 2016. Stoneyford Care Home was identified by the provider in March 2017 as a 'Project One Home' because the provider identified areas that required improvement in particular with how clinical risks were managed. Whilst the service had received additional resources we found limited improvements had made. The local authority and CCG had repeatedly raised ongoing concerns during 2017 about clinical risks not being effectively managed. Oversight and support by senior leadership had at times fallen short, impacting on the improvements required.

The registered provider has a statutory duty to ensure systems are in place and operated effectively to ensure quality and safety. This includes assessing, monitoring and improving quality and safety, mitigating risks and maintaining accurate, complete and contemporaneous records. Whilst a number of audits and checks were in place and the outcomes of these were shared with senior managers for oversight and scrutiny, governance at this inspection was found to be ineffective.

People's care records were found to not be completed consistently, meaning we could not be assured people's needs were being met in line with their assessed needs. When we asked who had responsibility and accountability of reviewing and monitoring people's daily records, including additional supplementary care records, we were told this was the nurses' responsibility. Whilst there was some evidence of oversight of clinical risks this continued to be a concern as we were aware the deputy manager who was the clinical lead and another nurse had recently left the service, and the registered manager had limited oversight of people's needs and had relied heavily on the nursing staff.

Whilst people's care plans and risk assessments were evaluated monthly the content of the care plan was not updated to inform staff of people's current needs. Some care plans and risk assessments were contradictory, resulting in unclear and confusing information for staff impacting on the care and treatment provided. Daily records used to record when people had been repositioned for their skin care needs, received personal care and food and fluid were inconsistently completed. This meant we could not be assured people's needs had been met as per their care plan and risk assessment, and recommendations made by external professionals not always followed. When people's healthcare needs changed such as weight loss, there was often a delay in action being taken such as a referral to the GP. Information about people's individual needs lacked detail or was missing, such as how to support people living with dementia at times of heightened anxiety or agitation. Needs associated with people's sensory needs had not been fully considered and impacted on people's ability to be as involved as much as possible in their care and treatment.

Our inspection identified repeatedly the over reliance on external professionals to identify what action was needed to meet people's needs  Even when recommendations were made these were not always acted upon or there was a delay in taking the required action impacting on people's safety and welfare. Just prior to our inspection there had been two occasions when visiting healthcare professionals had identified that

people as being at risk of choking and requiring staff supervision, were found alone eating. On the first day of our inspection we found a person who was known to be at risk of choking eating unsupervised. This was the third occasion within a four week period showing lessons had not been learnt and people were put at unnecessary risk. Where people had been granted with a Deprivation of Liberty Safeguard authorisation with conditions, these were found to have not been acted upon impacting on people's care and welfare.

Improvements were required with the management of medicines and with clinical leadership and the deployment of staff to ensure this was effective at all times and improvements were sustained. Whilst some improvements had been made in the prevention and control measures of infection and cleanliness, two audits completed by the CCG in June 2017 and October 2017 identified continued shortfalls.

All of the above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider has a statutory duty to notify the commission without delay of specific incidents including any abuse or allegation of abuse in relation to people using the service. This enables us to monitor the service and any incidents.

In August 2017 we were alerted by the local authority of two people who used the service who had safeguarding concerns raised by external healthcare professionals. One person was admitted to hospital and was found to be dehydrated. The second concern was in relation to a person's end of life care. On receipt of this information we contacted the registered manager who confirmed safeguarding investigation were in progress and that they had omitted to notify us, the Care Quality Commission (CQC). They then subsequently notified us at our request.

Additional safeguarding concerns were raised recently by external healthcare professionals in relation to a person who they identified had not receive their prescribed medicines for a four week period, they requested the registered manager make a safeguarding referral. On our inspection we saw a copy of the safeguarding referral completed by the registered manager had been sent to the local authority multi-agency safeguarding team as requested. However, the registered manager had omitted to notify the us of this safeguarding.

The local authority informed us they had received nine safeguarding referrals from external professionals since 1 September 2017 to date. We have received three safeguarding notifications from the registered manager during this same period. This meant despite the registered manager being reminded before our inspection of their regulatory registration responsibility to notify the Commission of any allegation of abuse, they had failed to do this.

This is a breach of Care Quality Commission (Registration) Regulations 2009 Regulation 18.

People who used the service spoke positively about the registered manager, who they described as approachable and friendly, saying they spent time with them. On the whole relatives were positive about the registered manager and echoed what people had told us as being available and approachable.

A reoccurring theme identified from feedback from external healthcare professionals was they sometimes lacked confidence in the registered manager understanding of the issues being raised or urgency to resolve concerns. Positive feedback was received about the supporting manager who was described by one external health care professional as, "Far more on the ball with involving other professionals for support."

On the whole staff were positive about the registered manager and said they were visible conducting daily walk around of the service where they engaged with people, relatives and staff. Staff reported there were regular staff meetings and improvements had been made with communication and organisation.

Relatives were aware of residents meetings and some told us they had received a satisfaction survey during 2017. We saw records that confirmed people and their relatives had opportunities to feedback about their experience of the service and the analysis of this feedback was made available for people. The most recent survey completed in June 2017 identified a reoccurring theme that improvements were required with the availability of appropriate activities. We spoke with the new unit residential manager who told us they recognised this was an area of improvement required and they had ideas of how they could work with the activity coordinators to bring about this change.

The provider had ensured that the service's previous inspection ratings were displayed as required.

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 18 Registration Regulations 2009 Notifications of other incidents |
| Treatment of disease, disorder or injury | The provider had not notified the Care Quality Commission of certain events which had taken place within the service as required.<br><br>Regulation 18 |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | People who used the service did not receive care and treatment that meet their needs and preferences.<br><br>Regulation 9 (1) (b) (c) (3) (g) Person Centred Care. |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The risks to the health and safety of people were not always assessed and the risks to people were not always mitigated as much as was reasonably practicable. The provider did not always work actively and effectively with external healthcare professionals to make sure that care and treatment remained safe for people.<br><br>Regulation 12 (1) (a) (b) (2) (I) |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not appropriately safeguarded against abuse and improper treatment. The systems and processes in place were ineffective. Action was not taken immediately to investigate when allegations became known. Action was not always taken in an appropriate time to act on Deprivation of Liberty Safeguard conditions.<br><br>Regulation 13 (1) (2) (3) (5) |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The nutritional and hydration needs of people were not adequately met.<br><br>Regulation 14 (1) |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. This included the process for ensuring that risks to service users were mitigated. Records of people's care and treatment was not completed accurately. Feedback from relevant persons was not always acted upon.<br><br>Regulation 17 (1) (2) (a) (b) (c) (e) |

**The enforcement action we took:**

An NOP to restrict admissions for people with nursing needs and positive conditions were imposed.