Advinia Care Homes Limited

Stonedale Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

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 people aged 65 and over. The service can support up to 150 people across 5 units, each specialising in either residential or nursing care for older people, including those living with dementia. At the time of our inspection there were 122 people using the service.

People's experience of using this service and what we found
Governance and quality assurance systems were in place however they remained ineffective. This meant people were exposed to unsafe care. There remains a repeated failure from the provider to ensure the delivery of safe, high quality care.

People were exposed to risk of harm as some of their risk assessments were either not reflective of their current needs or contained insufficient detail to help guide staff with how to support them safely.

Medications were not always given in line with best practice guidance and exposed people to the risk of harm.

There were systems and processes in place to help identify and report abuse, however they were not always being used effectively and there were some missed opportunities to safeguard people from harm.

People were not always being cared for in a dignified way. Some people looked unkempt, and some language used in care plans was not respectful.

People told us they liked the staff and they felt safe at the home. They described the staff as 'kind and 'caring' Staff liked the manager and felt they had given 'structure' to the home. The manager understood their duty to share information in an open and honest manner. There was enough staff identified to support people safely, however some staff told us they 'made do' with the numbers due to the level of support some people required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 last rating for this service was requires improvement (published 31 May 2023).

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

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 Regulated Activates (Regulations) 2014, and we identified a breach of Regulation 10 and Regulation 13 of the Health and Social Care Act 2008 Regulated Activates (Regulations) 2014.

Why we inspected
This inspection has been prompted in part by an increase in concerns around staffing and person centered care since our last inspection. This report only covers our findings in relation to the key questions safe, caring and well-led which contain those requirements. We also checked whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met, it had not.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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.

We have identified breaches in relation to risk assessments and safe care, medication administration, governance and dignity and respect and safeguarding.

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 with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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 Health and Social Care Act 2008.

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 4 inspectors, 2 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 and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stonedale Lodge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a manager in post who had submitted their application to register, this had not yet

been processed.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 December 2023 and ended on 20 December 2023. We visited the service on 7 and 12 December 2023 and worked remotely on 18, 19 and 20 December 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 members of staff including the manager, the governance managers, the maintenance person, registered nurses and care staff. We spoke with 7 people and 3 relatives about their experiences of care.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records including 19 people's care records which included medication administration records, and 4 staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection, we continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people's wellbeing and clinical needs were not always being assessed, mitigated or managed.
- One person, who was at risk of high blood pressure, had not routinely had their blood pressure taken regularly. On occasions when it was taken saw time when it was recorded as being high but no further action was taken. This was despite the person's risk assessment identifying they were at risk of having a stroke.
- Special dietary needs were not always being followed. For example, 1 person who was assessed as requiring a high fibre diet to help support their medical condition was not always getting this. This put them at risk of f developing complications such as constipation.
- Another person had experienced a choking incident which had not been recorded on their choking risk assessment. It was not always possible to tell from this person's food diary what texture of food they were being given, as there was no consistent recording of this.
- We also found no evidence of professional advice and guidance being sought about the choking episode and associated risks.
- People were not always protected from the risk of injury following falls.
- Those people diagnosed with diabetes were not always being managed appropriately. For example, one person's risk assessment did not contain enough information about the management of their blood sugar levels to keep them safe. Blood sugars were recorded inconsistently and varied in ranges and there was no intervention recorded if they were high or low, so we could not be sure people were safe.

Systems had not been established or used effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. this still remains a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

The provider responded following our feedback and has reviewed people's risk assessments.

● Following some incidents, the manager had been responsive and had made some changes to try and improve the delivery of care.
● Whilst we acknowledged the manager had attempted to implement learning from the last inspection, any changes had not yet become fully imbedded within the service.

Using medicines safely

At out last inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because medication, particularly the use of PRN medicine, was not always managed safely.

During this inspection, although improvement had been made in relation to the management of PRN (as required medicines), we found other concerns with people's medicines. Therefore, the provider remained in breach of regulation 12.

● Prescribed medicines were not always available to be given to people as there was no stock in the home. This placed people at risk of harm.
●When people had their medicines via a feeding tube, there was not always specific information available to support staff to give the medicines safely.
● Records were not always available to show where topical preparations, such as patches had been applied. Therefore, we were not assured they were applied as per the manufacturer's instructions which might have affected the effectiveness of the patch.
● Records to show that topical preparations, such as creams, had been applied were not always accurate. There was no information to direct staff where to apply the topical preparations. Therefore, we were not assured people's creams were applied as prescribed.

Medicines were not managed safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse;
● There were systems and processes in place to help identify and report abuse. However, these were not always being used effectively and there were some missed opportunities to safeguard people from harm.
● One person was putting others and themselves at risk of harm due to their behaviors and lifestyle choices and this had not been reported or acted upon.
● This person's risk assessments did not clearly describe the course of action to take to keep them and others safe from harm.
● Appropriate options had not been explored and reported in a timely way to ensure another person was adequately protected from potential abuse.
● While we acknowledge no physical harm occurred, these examples demonstrate safeguarding procedures were not always followed.

This is a breach of Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to our feedback and concerns and has since taken action.

● Staff described what action to take if they felt someone was being harmed or abused.
● Staff had been trained in safeguarding and there were policies and procedures in place to reflect this.
● People told us they felt safe at the home. Comments included "Yes, I do feel safe here. I'm as happy as I

can be here". Someone else said they felt "Safe and well looked after." All of the relatives we spoke with also said they felt their family member was safe. One relative said "Yes, as far as I can tell [family member] is safe here. I come most days."

Staffing and recruitment
● Staff were recruited safely after checks had been undertaken on their suitability to work with vulnerable adults.
● Dependency tools evidenced there were enough staff deployed across all units to support people safely. However, some staff told us they had to 'make do' as there was not always enough of them to provide the required level of care. We raised this with the manager who assured us they would look at dependency assessments to ensure they matched the level of care required.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
● The provider had adequate infection procedures in place. We observed some areas which required attention on day 1 of our inspection, however, when we returned for day 2, this had been addressed.'
● We observed staff wearing PPE, and there was a supply of PPE on each unit.

Visiting in care homes
● There was no restriction on visits and people could have visitors whenever they wished.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always being cared for in a dignified way.
- Some people on day 1 and day 2 of our inspection looked unkempt. They had long fingernails which did not look clean or well cared for.
- Some people's teeth did not look clean. Records for oral care evidenced people were not always getting offered support with this within reasonable times. For example, some records stated people had been offered support with oral care at 12am which was recorded as declined, due to the person being asleep.
- Across all of the units, we observed people's pillowcases on their beds were stained. Each bed had been made, meaning the pillowcases were not changed.
- One person told us they were cold, and they had asked a staff member for a duvet but had not received one.
- Record keeping relating to care records was not always captured in a way which was respectful. We found examples of some disrespectful wording in people's care records.

These examples highlight a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

The manager assured us action would be taken immediately. We have since received an updated action plan which states this has been addressed.

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

- People told us they liked the staff and they felt well cared for. Comments included "I like the staff on this unit, they will help me and listen to me." Another person told us "The staff are brilliant; they are really good and they will let me confide in them". Everyone else we spoke with described the staff as 'kind' and 'caring'.
- People told us staff respected their choices and ways of liking things done. One person said, "The staff know my ways." Another person told us how staff help them to get washed and dressed.
- We observed staff interacting kindly with people. Staff were knowledgeable about the people they cared for.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care ;Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014. This was because there was a failure to deliver adequate governance systems and repeated breaches of regulation around risk. We issued the provider a warning notice for this regulation.

During this inspection, we noted the provider had attempted to continue to imbed some new processes and there were governance systems in place. However, these remained ineffective. Therefore, the provider remained in breach of regulation 17, and had not met the terms of the warning notice.

- There was a governance system in place. Some assurance audits had been completed according to the organisations policy and there was a leadership team which oversaw audits and governance. However, governance systems remained ineffective as they were not thorough enough.
- Some care plan audits had not been completed. Therefore, there was missed opportunities to highlight some of the concerns we found during our inspection.
- Completed audits, such as an IPC audit had not identified the ripped chair covers we found during our inspection and had observed them all to be 'intact'.
- A medication audit had failed to identify some of the stock issues for one person which meant they went without a stronger pain relief for a number of days.
- Audits and checks of daily notes and records had not identified some of the inconsistencies we described in the safe domain with regards to risks, such as the blood sugar monitoring or food consistency requirements for people.
- There had been efforts from the manager to implement structure at the home, and staff spoke positively about this. However, governance systems were still not robust enough at this inspection. This is the third consecutive breach of regulation 17.

This remains a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
● The provider understood their role with regards to duty of candour and the requirement to be open and transparent when things went wrong.
● CQC had been notified of any significant events in line with registration requirements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics ; Working in partnership with others
● Staff had knowledge of people on the units they were assigned to work in and worked well together as a team.
● Staff were complimentary regarding the manager. One staff member said "[manager] has been great. They have given us a better structure."
● Relatives we spoke with said they felt involved in their family members care. However, most could not recall who the manager was.
● The manager was responsive and actioned our feedback during the inspection.