Stone Gables Care Ltd

Stone Gables Care Home

Inspection report

Street Lane
Gildersome
Leeds
West Yorkshire
LS27 7HR

Tel: 01132529452
Website: www.stonegables.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Stone Gables Care Home is a residential care home that was providing personal care to 26 people aged 65 and over at the time of the inspection.

Why we inspected: This inspection was prompted by a serious incident and information of concerns we received.

People's experience of using this service: During the inspection, we identified many concerns relating to people's safety. This included the service not having appropriate fire evacuation equipment in place. Also, a lack of training and guidance for staff on how to support people in the event of a fire. There were insufficient staffing levels during the day and at night which all put people at significant risk of harm.

We found the premises and equipment used to support people were not safe or clean. Issues relating to the environment, which we identified at our last inspection, had not been addressed. This included carpeting and flooring being very dirty and smelling of urine. Furniture including beds, armchairs, tables and dining room chairs were dirty and stained. Bedding and towels were very worn, some had holes and were stained. Mattresses were stained, smelled strongly of urine and were wet.

Staffing levels had not been calculated in line with people's needs. This meant staff struggled to meet people's needs. Poor standards of care were observed; people had dirty fingernails and some people had food stains on their clothing.

Medicines were not managed safely. Staff did not always have guidance to ensure they administered 'as required' medicines to people. Medicines were not stored safely and stock levels of medication were not recorded. Topical cream administration records were not always completed by staff.

Risks to people were not always properly assessed. This included moving and handling, nutritional needs, use of equipment and falls risks. The management team had failed to address this which meant people were at risk of harm.

Assessments of people's needs were not up to date which resulted in people's needs not being met.

Systems were not in place to monitor accidents and incidents.

Staff demonstrated a limited understanding of safeguarding and records showed they had not received appropriate training in this area. During our inspection, we reported our concerns to the local safeguarding team. This means external professionals will look into our concerns.

The provider did not always maintain appropriate records relating to the requirements of the Mental Capacity Act 2005 (MCA). There was a failure to properly oversee and make applications for authorisations

under the Deprivation of Liberty Safeguards (DoLS). People had not been included in decisions about their care.

People living with dementia did not have their care provided in line with best practice. This impacted on their quality of life and wellbeing. We have made a recommendation about this. People spent lengthy periods of time in the communal area; in the same chairs, only moving to attend for their meals in the adjoining room or to use the toilet.

An activity staff member was in post, but they had not received any training on how to plan and facilitate meaningful activities for people. Activities were often attended by the same people leaving others unstimulated.

People's nutritional needs were not always met and advice from health care professionals was not always followed. This put people at risk of receiving inappropriate and unsafe care.

Staff did not always receive an induction, or complete mandatory training to ensure they had the skills they required for their roles. Staff did not always receive supervision and appraisal of their performance.

In August 2018, the registered provider went into administration. The administrators had employed a care company to run the home while a buyer was sought and had oversight of their management.

The governance of the service was poor. The provider had an awareness of the issues we identified, but had not mitigated risks within the provision associated with issues we found.

After the first day of the inspection, we requested an urgent action plan from the provider to tell us how they would address the concerns we found. They responded with a plan which gave timescales for the completion of works. We visited the service again to follow this up and found that not all of the actions had been completed. We found there were no plans in place as to how these would be met. We continued to monitor the service regarding the improvements they were making.

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published 4 April 2018). This service has been rated Requires Improvement at the last three inspections.

Enforcement: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures 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 providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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 effective? The service was not effective. Details are in our Effective 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 responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Stone Gables 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 sustained a serious injury and died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with Care Quality Commission about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

Inspection team: On the first day of the inspection, two inspectors were present. On the remaining three days of the inspection, one inspector was present.

Service and service type: Stone Gables Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

It is a condition of the provider's registration that they have a manager registered with CQC. There was no registered manager at the time of our inspection. A temporary manager had been appointed at the time of our inspection. Within this report they will be referred to as the manager.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection, we liaised with the local authority and the safeguarding team. We did not ask the service to complete a Provider Information Return before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the information we held about the service including notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us

about. During our inspection, we notified the fire service. They visited the service and have requested that the provider acts to address the concerns they found. We also reported our concerns to the safeguarding team, the local authority and the infection control team.

During the inspection, we spoke with three people and two 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 also spoke with staff, which included agency staff, the cook and domestic staff. Throughout the inspection we liaised with the nominated individual, the regional manager, the head of quality, the temporary manager and the deputy manager.

During the inspection we reviewed five staff recruitment files, five people's care records and medication administration records (MARs). We also looked at records relating to the management of the service. We spoke with a visiting professional at the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection in December 2017, we found areas of the service were unsafe. We found risks to people's health and wellbeing were not always managed safely, guidance for staff regarding administration of medicines was not in place and poor management of infection control meant people were at risk of infections. At this inspection, we found improvements had not been made and these risks remained.

Assessing risk, safety monitoring and management; Preventing and controlling infection.
- The provider had failed to identify and manage risks within the service. This included fire safety systems which we found were not safe. As a result, people were put at risk of significant harm.
- Risk assessments in people's care records were not up to date and did not reflect people's current care needs.
- Due to the inaccuracies in people's care records, staff did not have proper guidance to follow on how to support people in the event of an emergency, or during their day to day life at the service. For example, people's personal emergency evacuation plans were not up to date. Nor did they specify equipment to be used to assist people in the event of an emergency.
- The premises and environment of the service were not clean or properly maintained. This meant areas of the service were in a poor condition. This included equipment, carpets, flooring, furniture, bedding and towels. The dining room flooring had not been fitted properly and was uneven. This posed a health and safety risk to people with sight and mobility problems. The communal lounge carpet and furniture smelled strongly of urine and armchairs were badly stained and smelled.
- Equipment used to assist people was not checked by a competent person and we found wheelchairs were not always safe to use.
- Equipment used to assist people was not clean.
- Cleanliness of the premises was not properly monitored. Where cleaning schedules were in place, these contained gaps where staff had failed to sign them.

Systems and processes to safeguard people from the risk of abuse.
- Prior to our inspection we had received a range of concerns about the service. We looked at these issues throughout the inspection and liaised with the safeguarding team and the local authority about this.
- Staff had completed safeguarding training but there were gaps in their knowledge of how to protect people from risk of harm.

Using medicines safely; Learning lessons when things go wrong.
- Medicines were not managed safely. This included storage and disposal of medicines, stock control, management of controlled drugs and administration of medicines.
- Record keeping relating to medicines was poor. Staff did not always have guidance to follow to administer

'as required' medicines.
● Audits relating to the management of medicines had been completed but actions identified had not been taken.
● The provider had not ensured that up to date and accurate records were kept relating to accidents and incidents that had occurred at the service. We saw documents were used to log incidents but there was no analysis being carried out. We were therefore unable to evidence that any learning from incidents took place.

This demonstrated a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
● The provider had not calculated staffing levels in line with people's needs which resulted in poor standards of care for people.
● Our observations were that there were not enough staff on duty which impacted on people in many ways. For example, people's personal care needs were not always met in a timely manner.
● Staffing levels were supported by the regular use of agency staff who did not have an induction to the service and told us they did not know what people's needs were.
● Staff told us there was not enough staff on duty on either day or night shifts. One staff member told us, "It's a real struggle to get things done for people. We know they have to wait but we just can't get around everyone. If we had more staff it would be better for people." A relative told us, "I don't think there are enough staff and the number of agency staff is unbelievable. They don't know people; I don't think it's safe."
● Staff told us baths and showers could not be supported as often as people would like, or need, due to staffing levels.
● After the first day of our inspection, the provider increased the staffing levels which we saw made some improvement to people's experience and the standard of care provided. They also changed the agency from which they used staff. New agency staff received an induction to the service and information about people's needs was communicated to them.
● Staff recruitment records showed that robust procedures were not in place.

This demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At our last inspection in December 2017, we found the provider was not acting in line with the requirements of the Mental Capacity Act and the associated code of practice. At this inspection, we found some improvements had been made. However, oversight of MCA processes and record keeping were not robust.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- There was a failure to monitor authorisations within the service. We found six people's DoLS had expired without action by the provider.
- The remaining service users were under a level of supervision which would mean an application to deprive them of their liberty lawfully should be made. This had not been done. This meant the provider was unlawfully depriving people of their liberty at the time of our inspection.
- Record keeping in relation to decisions made in people's best interests had not always been completed.

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

Staff support: induction, training, skills and experience.
- The provider had not ensured staff were suitably inducted, trained or supported to perform their roles.
- Staff records showed they had not always completed an induction and training before they commenced in their role.
- Training records showed most staff had not completed up to date training in a range of mandatory training subjects. Staff had completed refresher training for moving and handling. However, there were no records to show staff's competency had been checked.
- Agency staff were not inducted to the service. On the first day of our inspection, we found agency staff did

not have an induction before they started working at the service.
● Records were not always available to show staff had received supervision and an appraisal of their work performance.

This demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs.
● At our last inspection, we found the service required a considerable amount of refurbishment work. At this inspection, we saw that no improvements had been made, and many areas within the service still required attention.
● The service did not provide a stimulating environment for people living with dementia. There was a lack of reminiscence areas, memorabilia or adaptions to the environment.
● The regional manager confirmed that they had not considered best practice guidance in relation to the environment.
● After the first day of our inspection, the provider began to make improvements by changing the flooring and furniture in some of the ground floor communal areas of the service.

We recommend the provider review best practice guidance to ensure people are accommodated in an environment which meets their needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
● People's assessments were not detailed, up to date or reviewed on a regular basis.
● We observed care and support being delivered in a way that did not meet best practice guidance. For example, moving and handling techniques were unsafe for both people and staff.
● Where health care professionals had recommended equipment for people, the provider had failed to ensure this was obtained. This meant staff used inappropriate equipment to assist people.

Supporting people to eat and drink enough to maintain a balanced diet.
● People had care plans and risk assessments in place to identify their dietary requirements. These were inconsistent and were not always followed by staff. For example, one person's records stated they required a diabetic diet; this was not in place.
● Advice from healthcare professionals was not always followed by staff.
● The lunch time meal experience was not always well organised. Some people chose to eat in the lounge. As a result, they did not always receive support from staff who were busy supporting other people in the dining room.
● One relative told us the food was nice and their family member was offered a choice at mealtimes. However, we saw meals served to people where staff had not asked what the person wanted.
● One member of staff told us, "Some people can't make a choice but we know what they like to eat." A member of agency staff told us, "I haven't seen people being offered much in the way of choices. The food does look ok, and there is plenty of it."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.
● Advice from healthcare professionals was not always sought when people required it.
● People's care records did not demonstrate that they had been supported to see the dentist.
● A visiting professional told us they felt staff did their best for people but were limited due to how busy the service was. They also said the high use of agency staff had led to some information not being

communicated.

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.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity.
- Our observations were that staff were task focused in their interactions with people. We saw there were missed opportunities by staff to engage with people in a meaningful way.
- When people became distressed, staff did not appear skilled in how to support them. We saw one person was, at times, very unsettled and verbally abusive towards other people. Staff did not always intervene.
- A relative told us there were not enough staff to support people properly. They said, "People do not always get the support they need because the staff are too busy." One person told us, "Staff do their best but there are times when I know there is no point in asking for anything. They are run off their feet and wouldn't have time for me."
- The provider had failed to ensure staff had completed training on equality and diversity.

Supporting people to express their views and be involved in making decisions about their care.
- Our discussions with the provider about the improvements needed at the service identified that people had not been included, or asked for their views.
- There was no evidence to show people had been involved in making decisions about their care. This included care planning and reviews of care.
- People's life histories had not been included in their care records. Without this information, staff were less able to provide person centred, individualised care, based on people's experience and preferences.
- One relative told us they had seen their family member's care plan but were not sure if staff had read it.
- There were no details available for people relating to accessing advocacy services. Advocacy services represent people where there is no one independent, such as a family member or friend, to represent them and their views.

Respecting and promoting people's privacy, dignity and independence.
- People were not always treated with dignity and respect. People's appearance was not always considered by staff. Some people had long, dirty fingernails and wore clothing which they had not been supported to change after spillages at meal times.
- Staff did not always recognise when people required support to maintain their dignity.
- The provider had failed to ensure staff had completed training on dignity and respect.

This demonstrated a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

At our last inspection in December 2017, we found the provider had failed to ensure people's care records contained up to date information about their needs. Activities were not planned and facilitated in line with people's needs. People's wishes about their care at the end of their life had not been recorded in their care records. At this inspection, we found improvements had not been made.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support.

- The provider had failed to ensure accurate, person centred care plans were in place to guide staff on how to provide individualised care to people. They did not include information about people's up to date care needs, or information about their preferences.
- Care plans were not updated when people's needs changed or when professionals gave advice. Reviews of care plans did not indicate if planned care had been effective, or if it was meeting the person's needs.
- Daily recordings made by staff were often repetitive and failed to accurately reflect how care was provided in line with the person's care plan.
- One member of staff did not know that a person's needs had changed. This meant they continued to support the person using the wrong equipment.
- Care records did not always contain information about people's end of life care preferences.
- None of the staff had completed training on how to provide end of life care to people. The manager told us they would liaise with relevant professionals, but they were not confident that a good standard of care could be delivered due to the lack of training for staff.
- Communication care plans were in place. However, these lacked clear guidance for staff about how to communicate with people effectively. Care plans also did not evidence how the provider was meeting people's communication needs or meeting the requirements of the Accessible Information Standard (AIS).

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

- Activities arranged were limited and did not meet the needs of people using the service.
- One relative told us their family member loved being outside but had not been offered the opportunity to go out.
- The member of staff responsible for arranging and facilitating activities had not received appropriate training.

Improving care quality in response to complaints or concerns.

- The provider had a policy and procedure to advise on how to make complaints and concerns. This was displayed in the reception area of the service.

● The regional manager told us they thought there had been one complaint made by a relative. Records relating to this could not be found.
● People and their relatives told us they knew how to complain. One person told us, "If I had any complaints I would tell the staff; there are no complaints from me though." A relative told us, "I feel that the staff would listen if I had any issues but I'm not sure who I could go to above them."

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection in December 2017, we found the provider did not have robust systems and processes in place to enable them to have adequate oversight of the service. At this inspection, we found improvements had not been made.

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

- At the last three inspections in February 2016, March 2017, and December 2017, the service achieved a rating of requires improvement. After each inspection, they have failed to implement effective governance systems and processes to monitor and mitigate risks to people and achieve a rating of good. As a result, standards of care had not improved for people who used the service.
- In August 2018, the provider went into administration and a different care company had been employed by the administrators to oversee the home until it could be sold. A regional manager for the care company employed by the administrators was overseeing management of the home and visited weekly.
- The regional manager provided us with three quality audits they had completed. We saw these failed to accurately reflect some of the risks and concerns we identified during our inspection.
- A master action plan was in place for the service with oversight of the regional manager. Many of the actions had not been completed.
- The service did not have a registered manager. A temporary manager was in place when we visited.
- The number of regular staff at the service had reduced. Staff told us they were unclear about the future of the service and felt they were not included in the running of the service.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.

- Record keeping had not been properly monitored at the service and this impacted on staff's ability to provide person centred care. For example, people's care plans did not contain information about their life histories, likes and dislikes or their up to date care needs.
- Quality monitoring systems were not robust and as a result, people did not receive high quality care.
- The provider was not always open and transparent in how they communicated with people, relatives and staff.

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

- There was no evidence to show that the provider had engaged with the people using the service. There had been no attempts made to gather views and opinions on the service provision.

● Staff told us they did not feel included in the running of the service. They also said that staff meetings had not been held very recently were a new thing.

Continuous learning and improving care; Working in partnership with others.
● The provider failed to demonstrate how they were working towards improving standards at the service. Our findings showed that there had been a lack of improvement at the service and this had led to poor standards of care for people. It had also placed them at significant risk of harm.
● Staff did not always work in partnership with other healthcare professionals. Record keeping showed that advice and feedback was not followed and this put people at risk.
● At this inspection we found continued breaches of regulation. This demonstrated that learning and improvement had not taken place.

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