

Seth Homes Limited

Stoneacre Lodge Residential Home

Inspection report

High Street
Dunsville
Doncaster
South Yorkshire
DN7 4BS

Tel: 01302882148

Website: www.stoneacrelodge.com

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Stoneacre Lodge is a residential care home providing accommodation for people who require personal care. The home can accommodate 31 people. Some people were living with dementia. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found

We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, the outside store for clinical waste was overfull, the carpet on the upstairs corridor was extremely worn, items of clean and dirty laundry were seen on the same trolley, the windowsill in the sluice was damaged and not able to be kept clean. Staff were seen not wearing PPE correctly, touching their masks and on occasions, wearing the same gloves for different tasks.

Risks associated with people's care had been identified. However, risks to people were not always minimised. For example, the file containing personal emergency evacuation plans was not up to date, people's weights were not reviewed to ensure risks in relation to weight loss were monitored and one person was a high risk of pressure areas, but this had not been reviewed since December 2021.

People's medicines were not always managed in a safe way. Medication systems in place had not been followed by staff to ensure people received their medicines as prescribed.

On the day of our inspection we observed staff interacting with people and found there were enough staff to meet people's needs. Staff had been recruited appropriately.

The provider had a process in place to record and analyse accidents, this was last completed in October 2021. Analysis of trends and patterns to minimise future incidents, could be improved on.

There was a policy in place to safeguard people from the risk of abuse. A record of incidents was in place which showed actions taken and the outcome. However, this had not been updated since 2020, and we identified one concern that had been reported to the local authority but not to CQC.

The provider's system for auditing the quality of the service was not always effective. Concerns identified during the auditing process were not always resolved. For example, a pressure cushion audit stated that some cushions were stained but no record of any actions taken. We also found care plan audits had not been completed since December 2021, and the IPC audit not completed since August 2020.

There had been some changes in the management team which had led to the lack of auditing and senior staff having to lead the home with minimal experience of the manager role. The deputy manager post had been vacant approximately six months prior to our inspection, other members of the management team had needed to take time away from their roles. This had impacted on the day to day running of the home.

People did not always receive person centred care and support. For example, dining tables were bare, no placemats or tablecloths, one bedroom had a hole in the door where a lock mechanism had been removed and people could see in to the room from the corridor, the communal area was locked at both exits and limited access to the toilet, bathroom, and bedrooms, personal information was stored in an unlocked cupboard in the bathroom, the food menu was only available in a written format, there were no picture menus and people were not offered choices at lunchtime. Care plans were not person centred and reflective of people's current needs.

Staff training was out of date with some staff not receiving infection control training throughout the COVID-19 pandemic. Staff informed us they had been given handouts by members of the management team in regard to appropriate use of PPE and infection control.

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 good (published 27 October 2020).

Why we inspected

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

Concerns were identified. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stoneacre Lodge on our website at www.cqc.org.uk.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Stoneacre Lodge Residential 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.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

Stoneacre Lodge 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. Stoneacre Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection

This inspection was unannounced.

What we did before inspection

We looked at information we held about the service. This included details about incidents the provider must notify us about, such as allegations of abuse and serious accidents and incidents. We also reviewed all other information sent to us from other stakeholders, for example the local authority and members of the public.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with eight staff, including the registered manager, care staff and ancillary staff.

After the inspection

We continued to seek clarification from the provider to validate evidence found including training data and quality assurance records.



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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks associated with people's care had not always been managed effectively.
- Although staff were knowledgeable about people's needs, care documentation was not updated and therefore did not evidence what actions should be taken to mitigate risks. For example, personal emergency evacuation plans [PEEPS], were not up to date and some people did not have a PEEP in place, people's weights were not reviewed to ensure risks in relation to weight loss were monitored, one person was a high risk of pressure areas, but this had not been reviewed since December 2021.

Risks associated with people's care were not always managed effectively. Although we found no evidence people had been harmed, this was a breach of regulation 12(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, the outside store for clinical waste was overfull, the carpet on the upstairs corridor was extremely worn, items of clean and dirty laundry were seen on the same trolley, the windowsill in the sluice was damaged and not able to be kept clean.
- Staff were seen not wearing PPE correctly, touching their masks and wearing same gloves for different tasks.
- The last infection control audit completed by the management team was August 2020. Therefore, there was no evidence that issues had been highlighted and actions were being taken to address them.
- On the first day of inspection we found PPE hung over handrails in corridors which posed a risk of cross infection. On the second day of our inspection we found storage units had been installed.

The provider had failed to ensure infection, prevention and control policies and procedures were always followed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

- The visiting arrangements implemented by the registered manager followed government guidance. Relatives told us they were able to visit and confirmed they had a lateral flow test (LFT) prior to visiting.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals

visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

- Staff had been fully vaccinated against COVID19. The provider had seen evidence to support this.
- Staff and visiting professional's vaccination status for COVID-19 was checked on arrival and recorded.

Using medicines safely

- People's medicines were not always managed in a safe way.
- Some people were prescribed medicines on an 'as and when' required basis known as PRN, but protocols in place required more information and needed to be in place for all PRN medicines and not just pain relief. Following our inspection, the registered manager confirmed these were now in place.
- Handwritten entries on medication administration records were not double signed and there was no date of opening on bottles and there was no balance of the number of tablets still in stock. This made it difficult to evidence whether people had received their medicines as prescribed.

Processes in place did not evidence medicines were given as prescribed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The provider had a policy in place to policy in place to safeguard people from the risk of abuse.
- A record of incidents was in place which showed actions taken and the outcome. However, this had not been updated since 2020, and we identified one concern that had been reported to the local authority but not to CQC. This issue was reported retrospectively.

Staffing and recruitment

- The provider had a policy in place to ensure staff were recruited safely. This included pre-employment checks to ensure suitable people were employed.
- On both days of inspection, we found there were enough staff available to meet people's needs.

Learning lessons when things go wrong

- The provider had a system in place to ensure accidents were reported.
- Analysis of trends and patterns to minimise future incidents, could be improved on.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The management team consisted of the registered manager and a team of senior care workers. Changes to the management team over the last six months, had led to the lack of auditing and senior staff having to lead the home with minimal experience of the manager role.
- The deputy manager post was vacant, however, the provider informed us they had plans to recruit to this position.
- The registered manager was in the process of training senior care workers and one senior carer had recently completed a recognised training course in leadership.

Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The governance framework did not promote continuous learning to improve the service.
- There had been a lack of robust oversight from the provider to ensure quality and safe care was being provided to people.
- The provider's system for auditing the quality of the service was not always effective. Some concerns raised during the auditing process were identified, although some issues were not resolved. Other concerns identified on inspection had not previously been identified by the provider's governance systems.
- Care plan audits had not been completed since December 2021, infection control audit not completed since August 2020, and the pressure cushion audit stated that some cushions were stained but no record of any actions taken.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture within the home did not always promote person-centred care. For example, dining tables were bare, no placemats or tablecloths, one bedroom had a hole in the door where a lock mechanism had been removed and people could see in to the room from the corridor, the communal area was locked at both exits and limited access to the toilet, bathroom, and bedrooms.
- We saw personal information stored in an unlocked cupboard in the bathroom, the menu was only available in writing, there were no picture menus and people were not offered choices at lunchtime.
- Care plans were not person centred or reflective of people's current needs. However, staff were caring, kind and were knowledgeable about people's needs and knew people very well.

The systems in place to monitor and improve the quality of the service were not effective. Although we found no evidence people had been harmed this was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Relatives we spoke with felt their family members received person-centred care. One relative said, "The staff asked for a photo of [family member] prior to them moving to the home, so they could show the hairdresser how they liked their hair doing."

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

- Relatives we spoke with told us the management team and staff communicated with them well. They were confident staff would inform them of any changes in relation to their family members care.
- Relatives we spoke with said, "I am happy with [family members] care and I don't have any problems. [Family member] is well looked after. I visit at short notice and [family member] always looks well," and "I am happy that [family member] is cared for appropriately," and "[Family member] had to go to hospital and they [staff] rang straight away to let me know."

Working in partnership with others

- The management team had involved healthcare professionals when required to meet people's needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure people's risks were identified and managed to ensure their safety. Medicines were not always effectively managed and infection control procedures did not ensure people were protected from the risk of infection.</p> <p>Regulation 12 (1) (a) (g) (h)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to ensure the systems and processes in place to improve the quality and safety of the service provided were effective.</p> <p>Regulation 17 (1) (2) (a) (b) (c)</p>