Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Stonedale Lodge Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Situated in the Croxteth area of Liverpool, Stonedale Lodge Residential and Nursing Home offers personal and nursing care for 180 people. The provider is BUPA Care Homes (CFC Care) Ltd. Accommodation is provided on six units, each with 30 beds. Dalton and Anderton Units provide personal care for people living with dementia, Clifton Unit provides nursing care for people living with dementia, Blundell and Townley Units provide general nursing care and Sherburne Unit provides general personal care.

This was an unannounced inspection which took place over four days on 9, 10, 11 and 12 June 2015.

The service had a registered manager in post at the time of this 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Prior to our inspection we received information of concern regarding staffing levels at the home, standards of care and the cleanliness and hygiene of the home. The registered manager for the home also informed us [CQC] that seven staff had been suspended from one of the units in the home.

When we carried out our inspection we looked at these areas. We found evidence that supported the concerns around staffing and standards of care. We also found the management of medication in the home to require improvement. The health and wellbeing of people living at the home was placed at risk by these factors.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found there were risks to people. Medicines were being given late or missed, people's pain relief was not being managed, nutritional supplements were missed as they were not available, medications records were poor, medication administration did not always follow professional advice, 'give when required' medicines and creams were poorly recorded and monitored, medicines were left unattended and some medicines including a controlled medicine, were out of date. This placed people at risk of not receiving their medicines safely.

On the inspection we visited each of the six units in the home and checked on levels of staffing for each shift. As part of these checks, we looked at the skills and experience of care staff and how any staff absences were covered by the provider. We found there was insufficient numbers of staff for the home over a long period of time which meant some units had experienced staffing levels below the provider's stated safe levels. This had potentially placed some people at risk of harm.

We found the review of some people's health care needs was not consistent. This related mainly to people living on Blundell unit where we spent most of our inspection. For example wound care management had been missed in terms of on-going review, people were experiencing pain and this had not been managed effectively. We spoke with one visiting health care professional who told us that staff were not always consistent in carrying out planned or prescribed care.

We looked at the care record files for people who lived at the home. We found that some care plans and records were individualised to people's preferences and reflected their identified needs but many were not. We found examples were staff had not updated care plans and records as care needs had changed and examples where care planning had not been individualised with respect to people's individual care needs.

We were advised that currently a number of people living at the home had developed pressure ulcers following admission to the home. At present the routine programme for people needing assistance for pressure relief was not individualised and was carried out routinely four hourly. We were advised by the unit manager that many people needed attention two hourly but there was not always enough time and staff to carry this out.

On occasions we saw staff respond in a timely and flexible way. This was not, however, always the case and depended on numbers of staff. We saw a marked deterioration in the ability of staff to respond so people did not have to wait if they needed support.

When we spoke with staff they felt supported by their unit managers and they told us they felt there was an open culture and they were confident to report any concerns. They did not feel well supported by the site management however and felt there was a lack of communication overall. Staff did not feel their concerns about staffing were being listened to and acted upon. They felt as there had been a number of registered managers the frequent change was not good.

You can see what action we took at the back of this report.

We found the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice.

We found the home supported people who were on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

Summary of findings

On this inspection we found the service had failed to notify the Care Quality Commission [CQC] of people who had been placed on Deprivation of Liberty authorisations.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff we spoke with had a good understanding of the importance of maintaining people's safety in terms of reporting any concerns, including alleged abuse, to the manager of the home. We found the home had effective policies and procedures on safeguarding which staff were aware of.

We found during our inspection that people were assessed for any risks regarding their health care needs. The quality and consistency of these assessments varied on different units. We found some people's health care needs needed closer assessment and monitoring.

Prior to the inspection we received concerns around the cleanliness and hygiene in the home. At this inspection we found that the management of infection control had been an issue at one time but there had been improvements made. On the inspection we visited all of the units in the home and found them to be clean. Staff were seen to adhere to basic infection control practice when attending to people and serving meals. We saw there were hand wash facilities available in all bathrooms and toilets including liquid soap and paper towels for use.

We found there was training and support in place for staff. New staff we spoke with said they had attended and felt the induction prepared them for their role. Extra training was included for nursing staff and senior carers if needed. Staff felt well supported on the units in all areas except for staffing.

We discussed with staff and the people living at the home how meals were organised. We recorded mixed opinions but generally people told us the meals were good and well presented. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people. However, we saw examples on some days, on residential units who lacked enough staff, or nursing units who had no hostess for the day, where meals were late or rushed.

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. When staff were involved in delivering care we saw they took time to ensure they communicated well and reassured people. Most of the people living at the home we spoke with gave positive feedback regarding staff approach and attitude. We saw good examples of staff maintaining and prioritising people's sense of privacy and dignity.

Not all staff we spoke with had a good knowledge of people's needs. The managers on units told us of the value of building consistent relationships and having continuity to the care provided but felt this was an area that needed improving with more consistent staffing.

We asked people who lived at the home how they spent their day. We found variations between units as to the level of daily activities for people. On some units we found activities were taking place. People appreciated the activities they took part in and the hobby therapists displayed good skills in encouraging people to be involved.

A complaints procedure was in place and most people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to.

Special measures.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take

Summary of findings

action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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.

We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not followed.

There were not enough staff on duty at all times to help ensure people were cared for in a safe manner.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

Standards for the safe monitoring and control of infection control were in place.

Is the service effective?

Requires Improvement

The service was not effective.

Peoples health care needs were not consistently monitored effectively which potentially placed people at risk of poor care.

People living at the home had been assessed as having capacity to make decisions regarding their care. Staff understood and were following the principals of the Mental Capacity Act (2005) and knew how to apply these if needed.

We saw people's dietary needs were generally managed with reference to individual preferences and choice. Standards fell when staffing numbers were affected.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed positive interactions between people living at the home and staff. Staff were observed to treat people with privacy and dignity.

People we spoke with and relatives told us the manager and staff communicated with them about changes to care. People and/or their relatives were not always involved in on-going reviews of their care plans.

We saw staff respond in a timely and flexible way on occasions but this was not always the case and was dependant on numbers of staff.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive.

We found that planned care was not personalised to meet people individual care needs. Care planning and contemporaneous records were not always updated in good time when people's care changed. This resulted in care being missed.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Inadequate 

The service was not well led.

At the time of the inspection there was a registered manager in post to provide a lead in the home who was supported by other key personnel.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes but these needed developing to provide feedback more effectively.

There were areas of care management that needed to be improved and these had not always been identified by existing audits and systems in the home.

Stonedale Lodge Residential and Nursing 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.

This was an unannounced inspection which took place over four days on 9, 10, 11 & 12 June 2015. This was in response to concerns that had been raised. The inspection team consisted of five adult social care inspectors and two pharmacy inspectors,

We were not able to review a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had not requested this prior to the inspection. We reviewed other information we held about the home.

During the visit we visited all six of the units [houses] that make up Stonedale Lodge Residential and Nursing Home. These included three units supporting people living with dementia. Some of the people living at in these houses had difficultly expressing themselves verbally. 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 were able to speak with people living on each of the units in the home [over 25]. We spoke with 12 visiting family members. As part of the inspection we also spoke with five health professionals who were able to give some feedback about the service. We also liaised and spoke with the safeguarding social work team who were also involved in carrying out assessments of people living at Stonedale Lodge.

We spoke with over 35 staff members including care/ support staff and the registered manager. We also spoke with other senior managers in the organisation including the area manager, the quality assurance manager and the training manager.

We looked at the care records for 22 of the people living at the home, three staff recruitment files, medication records and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people living at the home and relatives/visitors. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received information of concern regarding staffing levels at the home, standards of care and the cleanliness and hygiene of the home. The registered manager for the home also informed us [CQC] that seven staff had been suspended from one of the units in the home.

When we carried out our inspection we looked at these areas. We found evidence that supported the concerns around staffing and standards of care. We also found the management of medication in the home to require improvement. The health and wellbeing of people living at the home was placed at risk by these factors.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We looked at medicines and records about medicines for 12 people on one nursing unit over two days. We found that on both mornings the medication rounds were lengthy and were not completed until 11am on one day and 12.45 pm on the second day. The lateness of the medicines round meant that people could not have the rest of their daily medicines at the correct times. One person had to wait almost an hour for their strong pain relief and was potentially in pain during that time. Another person was unable to have their tablets to control the symptoms of Parkinson's every six hours which may have caused them some distress.

Seven people were prescribed nutritional supplements and we found that there was none available for two people because they had run out. It was impossible to tell from the records if doses had been missed because nurses still signed that the supplement had been given even though there was no stock.

Almost half the people whose medicines were looked at did not have a photograph with their medication administration records. This meant that any new nurses on the unit would be unable to identify who they were giving medicines to. This placed people at risk of not receiving their medicines safely.

We saw that medicines were not always given safely as prescribed. One person had not been given one of their morning doses of insulin and there was no explanation as to why this important medication had not been given. Another person had their weekly pain relieving patch administered five hours later than it was due, which may have caused them to suffer from pain.

Although there were arrangements in place to give medicines safely with regard to food, we found they were not always followed. We found that medicines which should be taken before meals or food were signed as given at meal times. If medicines are not given at the correct times with regard to food they may not work properly.

Medicines were not always given with regard to visiting health care professionals' advice. One person had a letter from the dietician decreasing the quantity of food supplement they were prescribed, however nurses continued to administer the higher doses without explanation. We also spoke with a visiting health care professional who told us that they had concerned that the nurses failed to follow their advice on occasions.

We saw that 11 people were prescribed medicines to be given "when required". We saw the home had protocol forms for nurses to complete in order to give guidance about how to administer these medicines safely and consistently. However we saw that the forms were not completed in sufficient detail to provide good guidance or were not competed at all. We saw there were no protocols for medicines prescribed to ease severe pain or for people who suffered from anxiety or constipation.

We found that most medicines supplied in the monitored dose system were given as prescribed. However we found when medicines were supplied in traditional boxes they were not given as prescribed. We found that fewer doses were given than had been signed for. We also found that nurses had signed that they had administered inhalers when the dose counter on the inhaler showed that few doses had been given than had been signed for.

We looked to see if creams were applied as prescribed and we found the records about creams were so poor it was not possible to tell if creams had been applied properly. Carers told us they applied creams but we saw that nurses signed to say they had applied the creams that the care staff had applied. There were forms available for staff to complete to show where and how often to apply prescribed creams. However we found they were not always competed so staff could not apply creams safely and consistently.

Inadequate

Is the service safe?

We also found that nurses failed to account for medicines. We saw that one person was prescribed a mouthwash which had only been used twice; however the nurse on duty was unable to find it. Another person was prescribed an antipsychotic medicine in liquid form, we found that 21 doses were missing and could not be accounted for.

Three of the 12 people whose records we looked at were prescribed a thickening agent to be used in all their drinks and fluids to prevent them from choking. Care staff on the unit on the second day of our visit could not tell us which people needed their fluids thickened. We saw there were no records available for care staff and hostesses to refer to when they were serving drinks. Staff did not make any records when they had thickened drinks.

During our inspection we found that medicines were left unattended. We saw that they medicines trolleys were left open when nurses went to get drinks for people or when they were giving people medicines. We saw that insulin and thickening powder were also left unattended during this time. Creams were kept in people's bedrooms without a risk assessment to show it was safe to do so.

Medicines were stored in a dedicated clean and tidy medicines room. However waste medicines were not stored correctly. Waste medicines were in an unlocked cupboard on the first day of our inspection and in open topped bins on the floor of the medicines room on the second day. National guidelines for the storage of such medicines were not being followed.

We found that controlled drugs were accounted for and were stored safely. However we saw that one person's morphine solution had gone out of date and the records showed that they had been given one dose of the medicine after it had passed the expiry date. If medicines are administered outside the expiry date they may become less potent and not work effectively.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014 (Part 3)

On the inspection we visited each of the six units in the home and checked on levels of staffing for each shift. As part of these checks, we looked at the skills and experience of care staff and how any staff absences were covered by the provider. We found there was insufficient numbers of staff for the home over a long period of time which meant some units had experienced staffing levels below the providers stated safe levels. This had potentially placed some people at risk of harm.

During the inspection we asked the registered manager to confirm the minimum staffing levels for each of the units in the home. We were told staffing levels were: Blundell unit – two nurses and four care staff on days and one nurse and three care staff for nights [this reduced from 12 midnight as one carer [twilight] finished shift; Townley unit – two nurses: four carers days and 1:2 nights; Clifton unit – two nurses: five carers days and 1:3 nights; Anderton and Dalton units [residential] – five carers a.m. and four carers p.m. and three carers nights; Sherburne unit [residential] – four carers all day and three carers at night. The provider had assessed these were the staff needed to ensure safe care was being carried out.

We were told by the registered manager that staffing was an issue in the home and it was difficult to recruit and retain regular nursing staff which had meant a high dependency on agency nurse cover, particularly on nights. There was also a need to recruit more regular care staff. The manager confirmed the following: Use of Hostess [9-5 to help with meals] - only on nursing units; we were told these were 'much needed' but not replaced if sick or on annual leave. The registered manager said this was being reviewed with a need for extra care staff to cover absence as the need was recognised. The home was still budgeted for a 'floater' [care staff who could cover shortages or short term staffing need] –and this staff was used daily to cover shortages on units. There was a 'twilight' shift on Blundell unit working from 8pm to midnight. New nursing and care staff had been recruited and were due to start in the near future but this still left a further 78 hours care staff hours to staff the home fully and registered nurses were needed to cover 36 hours on days and 108 hours night cover.

All staff spoken with confirmed, to a lesser or greater extent, that staffing was the major problem with the home. Typical comments included: "There's a lot of staff coming and going". '' lots of changes to the staff team and "You get used to the carers and they move them and bring new ones in." ''staffing has been down to three on occasions more recently [Sherborne]. "It feels OK at four but lately it has been down to three." "We have rang the office a few times

to ask for more staff but they never send anybody over'', "They're trying to even out other units and take staff off here" "It's too hard for the staff we don't get our breaks and no lunch."

Staffing was seen to be lower than stated numbers on four of the six units over the four days of the inspection [at various times]. This was mainly due to sickness and staff having to move to cover other units. On one day of the inspection an example of the disruption and effect on care occurred on Anderton and Townley Units. We arrived on Anderton unit at 9.15am. There was one senior carer administering medication and three carers on duty to support 24 residents. Staff told us that a carer had been taken off to cover Townley Unit as they were short. There was no hostess on Anderton Unit so staff were also trying to serve breakfast. At 9.55am people were just being served breakfast. We were told by staff this was later than usual. One service user told us they had not had a cup of tea since they woke up and they felt they had been waiting for some time for a drink and their breakfast.

We arrived on Townley Unit at 9.45am. This is a nursing unit with 24 highly dependent service users at the time of our visit. There were two nurses and three carers on duty. One of the carers had been brought over from Anderton Unit. For health reasons the carer was not able to assist people who required assistance with moving and transferring. This member of staff was later sent back to Anderton Unit and a member of staff from Mersey Parks [another BUPA home] was brought over to Townley Unit. The people on one side of the unit had not been supported with their personal care because the nurses were both administering medication and the two carers on duty were supporting people on the other side of the building. We asked the nurses which people had been attended to. Nursing staff where unable to tell and referred us to the care staff. We asked the carers at 10.15 whom they had seen over the other side of the building and they said they had not been able to see anybody up to that time. This totalled 14 people who had not been seen. We checked on the 14 people. One person was in bed and had been incontinent and their mouth appeared dry. This was still the case when we returned to the unit at 10.40am. We brought it to the attention of a nurse that this person needed support to be changed as they had been incontinent of urine. One of the nurses at this point said they had ensured everybody had had a drink and breakfast and had been turned when they commenced their shift. We saw nothing to indicate that people had been given a drink or breakfast. The exception was a carer who was brought over from Anderton Unit and they were assisting one person with breakfast. At approximately 11am we saw that the activities co-ordinator was acting as a carer and supporting people to get up. A relative told us their family member had not been assisted to get up until a similar time the day before.

We made observation of care being carried out on Townley Unit for 20 minutes over lunch time [12.40 – 1300]. Staff had a lot of people to support who required assistance with their meals. One person was asking for assistance to use the toilet on three occasions. They waited about 10 minutes until a nurse acknowledged them and a carer took them out of the lounge. This reduced the number of staff available to support people further. The phone was also ringing out on a number of occasions as all staff were busy supporting people with their meal. One person was observed to get up from their chair and very unsteadily started to walk. We had to get the attention of the hostess to support them.

Moving staff across the different units was unsettling for people living at the home and staff. We saw the direct impact of staffing levels upon residents particularly on Townley Unit.

Following the suspension of a number of staff, the registered manager had made arrangements for staff from other units to work on this unit. On the first day of our inspection all the care staff, with one exception were from other units. Inspectors spent three days on Blundell unit.

At the time of our inspection there were 28 people living on Blundell Unit. We saw the duty rota for Blundell Unit from 22 may – 4 June. This showed the 'twilight' shift rota for 12 out of 14 nights. We spoke with the nurse who was the night duty manager who explained and confirmed the twilight was moved from Blundell every night over this period to other units due to shortages / need. When we asked the registered manager about this they were unaware these staff moves had taken place. This left Blundell Unit short of the provider's stated numbers of staff to deliver safe and effective care over this period.

On one of the days of our inspection (11 June 2015) we found Blundell Unit were two care staff short. This left two nurses and two care staff to care for 28 people at the time. It was explained by the nurse in charge that two staff had phoned in sick. The high risk to people was evidenced with

respect to medications. The nursing staff were familiar with the unit and the people but the care staff were not familiar and therefore the lack of information about [for example] food thickeners meant that people were put at great risk of harm. There was also no 'hostess' on duty who may have had a record of this. The nurses advised us they only worked two and three days a week which meant that there were four and five days when unfamiliar and agency nurses were on duty. We found a lack of information in care files such as PRN [medication to give when necessary] protocols in place which meant nurses, particularly agency nurses who did not know the people they supported meant that people were at risk.

We visited Clifton Unit on the first two days of the inspection. This unit supports people living with dementia. They are highly dependent and require 24 hour nursing care. A staff member reported safe staffing for days on the unit but said that night cover was an issue. There was a lot of agency staff cover as employed nurses were not available. We reviewed the duty rota for two weeks from 22 May 2015 to 4 June 2015. The rota was confirmed as correct by the unit manager. We saw that on the night of the 22 May 2015 Clifton unit had been staffed with one nurse and three care staff until midnight. This however had been reduced as one care staff had been moved to cover another unit. This left the night shift short by one carer. Eight of the fourteen shifts on nights had been covered by agency staff. This supported evidence of a lack of regular nursing staff for Clifton Unit. On the night of 5 June 2015 we saw there had been no nurse cover at all available for Clifton unit due to sickness. We asked how medications were given at night time and we were told by manager staff member these were given by the nurse finishing the day shift and the keys were then handed to the night service manager. This was confirmed by the registered manager who explained that agency staff cover could not be sought. There was no extra care staff cover organised. This meant the unit had three care staff to look after the nursing care needs of 28 people.

In all of the above examples the staffing numbers were below the minimum staffing the provider would expect to deliver safe and effective care and people were put at unnecessary risk of harm.

We asked for duty rotas for all of the units in the home. The duty rotas seen on individual units did not always record the same staffing numbers as the staffing rota held in the manager's office. The registered manager gave us a copy of the 'staff on duty record'. This was described as an accurate record of staffing numbers as the figures were taken from the payroll. The rota covered eight weeks from 10 April 2015 to the 4 June 2015. We saw that gaps appeared every week on this rota. For example, the week ending 28 May 2015 all six units were short staffed at various times during the week. Of particular note was Anderton Unit on 26 May 2015 where three care staff were supporting 25 service users; Blundell unit 28 May where four staff [two nurses and two carers] were supporting 27 service users on the PM shift; Dalton unit on 23 & 24 May where three carers were supporting 28 service users on the PM shift; Sherborne unit on 22 & 25 May when three care staff were supporting 27 service users on the PM shift.

There were similar examples over all of the eight week rota showing that the home were struggling to maintain adequate staffing over a long period of time.

We found staffing numbers were below the provider's stated levels to deliver safe effective care. This means any unplanned eventualities would be difficult to respond to [as evidenced on Blundell Unit on 11 June 2015]. There was a high risk of care not being delivered in a timely or safe manner.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff we spoke with had a good understanding of the importance of maintaining people's safety in terms of reporting any concerns, including alleged abuse, to the manager of the home. We found the home had safeguarding policies and procedures which staff were aware. Staff also attended 'statutory' training which included being made aware how to recognize and report abuse.

Just prior to our inspection the managers of the home had responded quickly to two reported allegations of poor and inappropriate care practices. They followed the agreed guidance and were working with Liverpool City Council in

Inadequate

Is the service safe?

terms of supporting any investigation. Previously the home have had other examples where they had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating to help ensure any lessons had been learnt and effective action could be been taken. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the Local Authority safeguarding team were available along with the home's safeguarding policy.

We found during our inspection that people were assessed for any risks regarding their health care needs. The quality and consistency of these assessments varied on different units. For example, risk assessments had been carried out to assess people's risk of developing a pressure sore and risk assessments for the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool. Weight charts were seen and had been completed appropriately on a monthly basis. We found that there were examples where these assessments had been completed well and were regularly updated. There were examples, on Blundell Unit for example, where some required updating and monitoring. For example, a risk assessment for nutrition was out of date as it required review in May 2015; the current level of risk for the person was therefore not assessed. Another person had a pressure area which was last reviewed on 27 May 2015. Lack of review and monitoring places people at risk of their health deteriorating.

Prior to the inspection we received concerns around the cleanliness and hygiene in the home. At this inspection we found that the management of infection control had been an issue at one time but there had been improvements made. We were shown infection control audits carried out by Liverpool Community Health [LCH] infection control team on two of the units in April 2015. The home had also carried out similar audits and we saw that areas for improvement had been identified. We spoke with LCH who told us the home had sent an action plan which they were satisfied indicated the home were now meeting standards. On the inspection we visited all of the units in the home and found them to be clean. Staff were seen to adhere to basic infection control practice when attending to people and serving meals. We saw there was hand wash facilities available in all bathrooms and toilets including liquid soap and paper towels for use. We spoke with some of the domestic / cleaning staff who were able to tell us about what to do in case of an infectious outbreak. At the time of the inspection managers were not able to show us any evidence of further internal audits having taken place since April 2015 although the area manager commented that there had been a lot of work done in the area of infection control.

Requires Improvement

Is the service effective?

Our findings

We looked in detail at the care received by some of the people living Stonedale Lodge Residential and Nursing Care Home. We found the review of some people's health care needs was not consistent. This related mainly to people living on Blundell unit where we spent most of our inspection. For example wound care management had been missed in terms of on-going review. Two people were experiencing pain and this had not been managed effectively. We discussed some of these omissions and staff related them to inconsistencies in staffing. There was a risk that if regular nursing staff were not available to monitor health care needs there could be gaps or omissions in care. We spoke with one visiting health care professional who told us that staff were not always consistent in carrying out planned or prescribed care. A social work team who visited the home at night on Clifton Unit reported concerns that the agency nurse in charge of the unit was not fully aware of one person's immediate health care needs. This person had been seen by the GP earlier and had recommended specific observations to be made.

These findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas we found good examples of care being carried out effectively for people needing support with their health care needs. For example, on one unit [Sherburne] food diaries were in place for people who had lost weight or were at risk of becoming nutritionally compromised. Fluid diaries were also maintained if required. Some people were weighed weekly and others monthly in line with their individual circumstances / risks. On Clifton Unit we reviewed two people's care and saw that there was good liaison with community health care professionals and there were regular reviews of care around colostomy care and people living with dementia [for example].

We saw that the community matron visited the home on a regular [almost daily] basis and liaised with staff with respect to people health care needs. There were entries in care files to evidence regular reviews and input by other health care professional such as, the GP, district nurses and dieticians. On one of the units a GP was visiting to assess a person and the community matron another. Most people living at the home and visitors we spoke with said that staff liaised well with health care professionals who acted to support people. On one unit feedback from two visiting professionals was good. They told us staff acted upon their advice appropriately. Feedback from relatives was generally good and they told us they thought the standard of care provided was good. People's care plans showed regular input from outside professionals. One relative commented; ''My [relative] attended hospital last week and staff escorted them and gave me the feedback.''

We looked at the training and support in place for staff. The training manager told us about the induction programme for new staff. This was covered over an initial four to five day programme covering subjects such as; role of the care worker, equality and diversity, dementia awareness, medicines, and health and safety issues. New staff we spoke with said they had attended and felt the induction prepared them for their role. Extra training was included for nursing staff and senior carers if needed.

The training manager showed us a copy of the staff training matrix which identified and plotted training for staff in 'mandatory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness. The training manager told us that nearly all staff [99%] were up to date with mandatory training.

Staff felt well supported on the units in all areas except for staffing. They told us they were up to date with their training. Some staff told us they had regular support sessions with their line managers such as, supervision sessions and staff meetings. We found these were not consistent on all units however. Some unit managers said that lack of effective time for their management role meant that 'staff supervisions were behind'. Staff seemed a little unclear as to what constituted supervision and appraisal and how often they were provided with both. For example, on one unit, the unit manager said they had just started supervision with the seniors and had completed some of these. We were shown a 'supervision matrix': Out of 17 staff, 4 had had just one supervision so far this year.

The manager told us that some staff had a qualification in care such as NVQ [National Vocational Qualification] or Diploma and this was confirmed by records we saw where 45% of staff had a qualification. Other staff were being signed up to start this training. Staff spoken with said they felt supported by the training provided.

Requires Improvement

Is the service effective?

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. People living at the home varied in their capacity to make decisions regarding their care. We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. For example on one unit we saw a well-documented and thought out decision around using medication covertly for one person in their best interest. This included input for professionals and also the opinions of relatives.

We had some discussion with staff on Clifton Unit, which specialises in nursing people living with dementia, re their understanding of the MCA. Although care practices indicated staff were following good practice we found some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used. Three senior staff including the unit manager had not had specific training in the MCA. The unit manager said they would review this with the training manager.

Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use. We found the home supported people who were on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the registered manager and senior staff knowledgeable regarding the process involved if a referral was needed. We reviewed the authorisations in place for some people and found the process had been followed and was being monitored in liaison with the local authority.

We discussed with staff and the people living at the home how meals were organised. We recorded mixed opinions but generally people told us the meals were good and well presented. A person said, "The food varies and sometimes isn't very good. On one unit three people told us they didn't think there was a good choice of food." Another person told us: "The food isn't great and there's no fresh fruit." Other people said the food was "OK" and "Fine I like it." We observed the dinner time meal on some of the units and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated, unless there were staff shortages, and that staff took time to talk to and socialise with people. The [nursing] units had a designated 'hostess' who provided extra support with meals. On the whole people were not rushed with their meals. We saw staff asking people if they wanted an alternative to what was being offered. These observations were general. However, we saw examples on some days, where meals were served late or rushed. This was due to a lack of staff on the residential units and a hostess for the nursing units.

Requires Improvement

Is the service caring?

Our findings

Most of the people living at the home we spoke with gave positive feedback regarding staff approach and attitude. Some comments we recorded included, " I'm not sure how long I have been here but all the girls are lovely – they are very nice with me" and "You have only got to ask – the staff are very caring and really patient with everyone.'' Likewise relatives we spoke with were equally positive; "We can`t complain about any of the carers – each time we come in they are busy caring for people – they are very good'' and "Some of the staff who have been here a while are very caring – they do a really good job." One relative qualified their view of staff by staying, ''Staff work very hard and do their best. They are kind and helpful but there are too many changes – you never know whose best to talk to.''

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. When staff were involved in delivering care we saw they took time to ensure they communicated well and reassured people.

We observed staff in the communal areas of all the units we visited. Staff interactions towards people were respectful and pleasant. During these interactions, staff appeared to listen carefully to and made efforts to communicate with people effectively. If people presented with challenging behaviour in terms of verbally negative comments, staff were seen to handle these sensitively.

We asked whether privacy was respected. Staff we spoke with described how they maintained people's privacy and dignity whilst supporting them with personal care; for example closing doors, blinds, using towels to cover and protect people's dignity, explaining to people and asking their permission to carry out tasks. People we spoke with confirmed this general approach by staff.

On two units we heard some inappropriate use of language when staff were talking about people on the unit. For example, using the term "done" when referring to having supported a person with personal care or meals; "I've done…." And "Who are you doing?" We also heard the term 'feeders' being used on one occasion referring to people who needed assistance with their meals.

People told us they felt they were listened to and generally staff acted on their views and opinions. One person said; ''The staff do listen when you talk to them. There's not always a lot of time though – they're very busy.'' We saw different levels of staff 'socialisation' on different units. If there was a high ratio of very dependent people in terms of personal care [for example the dementia nursing unit] this time was reduced.

Over the four days of the inspection we saw the home as generally busy with lots of daily care and activity. We saw staff respond in a timely and flexible way on occasions but this was not always the case and depended on numbers of staff. Staff had difficulty responding to people's needs in a timely manner when staffing numbers dropped. Not all staff we spoke with had a good knowledge of people's needs. The managers on units told us of the value of building consistent relationships and having continuity to the care provided but felt this was an area that needed improving with more consistent staffing. We looked at the results of feedback questioners sent out to people living at the home and their relatives. The feedback varied but one of the areas for improvement was, 'the promptness of staff attending to my relatives needs'.

We saw that advocacy was available for people if needed and this was advertised on units. We saw at least one example where a person was receiving support from a local advocacy service.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at the home how staff involved them in planning their care. People who were able to give an opinion and relatives we spoke with varied in their opinions. They said they felt involved in most key decisions but input varied. Most of the people living on the units or relatives said they had not seen a care plan although we did see references in care notes to 'relative interviews' were relatives had been advised regarding specific issues such as an accident. It was clear, however that people living in the home or their relatives were not activity engaged in on-going formal reviews of their care. One relative commented they had raised many issues regarding their relatives care but had never been involved in a 'care review' or seen the care plan of their relative. None of the care records we saw had a care plan which showed evidence that people or their relatives had been involved [none had been signed for example].

We looked at the care record files for 13 people who lived at the home. We found that some care plans and records were individualised to people's preferences and reflected their identified needs but seven were not. We found examples were staff had not updated care plans and records as care needs had changed. Also, examples where care planning had not been individualised with respect to people's individual care needs.

Blundell Unit supports service users who have general nursing care needs. We found serious concerns with the way care was being planned and delivered on this unit which placed people at risk of harm. For example, we saw the care records for one person showing weight loss. Records were confusing and appropriate referrals had not been made to the GP or dietician as indicated. On further review we saw the records had been incorrect when recording the person's weight. Care records had been incorrect and had not assessed the level of risk correctly.

We looked at how wound care was managed on Blundell Unit. We were advised by the unit manager that one person had a pressure sore treated by a dressing. No information about the wound dressing was recorded in the care file. This meant that nursing staff, particularly nursing staff such as agency staff, had insufficient information to carry out care. Another person had a wound to their leg but staff were not able to tell us when the dressing had last been changed. Another person had a number of pressure sores. Three of these wounds were due to be redressed and assessed on 5 June 2015 but had not been carried out. During the inspection the wounds were assessed by a visiting community professional and redressed. The manager of the unit was aware that the dressings needed to be reviewed however they told us may have not been done on due date as this was around the time when a number of staff were suspended.

There were other examples of inadequate personalisation of care on Blundell Unit. We spoke with a relative who raised concerns about the standard of personal care for one person's eyes as they had not been cleaned effectively. This had been raised with staff previously but the care had not been personalised to accommodate this. Likewise preferences around breakfast times had not been adhered to although again this had been raised by the relative. This meant the person went for a long period with nothing to eat. The person's nails had not been cut for some time. We saw these were digging into the palm as they had a contracture to their hands. The relative told us they had raised this previously with staff. There was no protective roll in place to protect the person's hands. These examples showed lack of personalised care involving people living at the home.

We looked at the care of a person who was at risk of falls. There was no daily record of care recorded the day previously [9 June 2015]. We were advised by the unit manager that the person had had a fall the previous night. There was no record of this in the daily report. This meant there was no contemporaneous record in the care notes documenting the fall or documenting what care had been delivered. The incident form could not initially be located and was not found till late in the day. Staff were not therefore fully aware of the circumstances of the fall or of any follow up needed.

The unit manager on Blundell advised us that currently there were service users with pressure ulcers, seven developed after admission to the unit. The unit manager said there had been some discussion with staff on the unit around the frequency of toileting and changing people to ensure their comfort and wellbeing was not regular enough. They told us this might be a factor in the high rate of pressure sores and this needed to be improved. At present the routine programme for people needing

Inadequate

Is the service responsive?

assistance was not individualised and was carried out routinely four hourly. We were advised by the unit manager that many people needed attention two hourly but there was not always enough time to carry this out consistently.

This is a breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at the daily social activities that people engaged in. We asked people who lived at the home how they spent their day. We found variations between units as to the level of daily activities for people. On some units we found activities were taking place. The home employed 'hobby therapists' who were responsible for initiating some activities within the home and we saw some interactions at various times which were positive and helped people to have a greater sense of wellbeing. One activity hobby therapist had been off work for eight weeks so activities were limited in some areas. When we saw activities taking pace for people they were well appreciated and the hobby therapists displayed good skills in encouraging people to be involved.

We asked how managers were planning to improve the level of personalised care in the home, particularly on Blundell Unit. Unit managers said that the level of personalised care was dependant on the consistency of staff, their knowledge and relationship with people living at the home. The current concerns around staffing levels meant this potentially was difficult to achieve.

A complaints procedure was in place and most people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to. We saw recent examples of complaints that had been investigated and a response made. One person we spoke with [relative] had made complaints about the service they told us that the response had varied but they had received a reply to their concern. One relative raised concerns about the care of their family member at the time of the inspection and was able to speak to the registered manager about this.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post at the time of the inspection. We spent time talking to the registered manager and asked them to define the culture of the home and the main aims and objectives. We were told that they were trying to encourage better communication with staff on the units. For example the registered manager had regular weekly meetings with unit managers to update and discuss issues. We were informed by senior managers at the end of the inspection that the registered manager had resigned their post at the home.

When we spoke with staff they felt supported by their unit managers and they told us they felt there was an open culture and they were confident to report any concerns. They did not feel well supported by the site management however and felt there was a lack of communication overall. Staff did not feel their concerns about staffing were being listened to and acted upon and they felt there were frequent changes to the registered manager and this was not good.

On this inspection we found failings in the staffing of the home, medication management and safety and nursing and personal care standards that the manager and provider had not been fully aware of or had not acted on effectively.

Management systems and support in place failed to respond to the staffing situation on Blundell Unit on 11 June 2015. Despite the unit having experienced a staffing crisis when seven staff where suspended on 3 June 2015 we found there was a lack of monitoring and oversight on 11 June to events as they presented themselves. There was a lack of urgent response by the registered manager or any senior manager who did not visit the unit again following an initial visit early morning [at the request of the nurse] to assess staffing levels. The registered manager was therefore not aware of developments over the day. Communication with the unit was poor. The unit was not effectively covered until issues were highlighted by inspectors at 13.30. It still took two hours to fully staff the unit. Inspectors did not observe any offer of direct support from senior managers; site managers did not visit the unit over this period.

We found the management systems in place to cover staffing were not adequate. The initial response to the staffing crisis on Blundell when staff were suspended showed adequate response in terms of allocation of numbers. This was due to BUPA resources with other BUPA homes in the vicinity able to support. However, recruitment processes in operation, management of sickness, use of agency, use of 'floater', use of 'twilight shift' and the use of the 'hostess' had collectively failed in various ways to meet the staffing needs of the home over a sustained period. This was evidenced by the staff duty record for past two months which show regular shortages to the provider's stated minimum numbers and further exemplified on Blundell Unit on Thursday of the inspection.

We found the systems in place to monitor staffing numbers on units to be inadequate and confusing. When trying to ascertain staffing levels from duty rotas on units, we found these did not match rotas held by managers. Duty rotas on units were not reflective of actual staffing numbers that staff had worked. It was initially difficulty to get staffing numbers of units from the registered manager as information about staffing kept was in a number of places; for example information for nurse agency use was kept in a separate diary. We were able to finally collate information with the 'staff on duty record' produced the day after we asked for this information. Evidence would indicate that accurate information was not readily available to make management decisions regarding staffing on a daily basis.

A member of night staff was interviewed who said that registered manager had never carried out a visit at night [despite staffing issues on nights]. When we spoke with the registered manager, they was not aware [for example] of the use of the twilight shift on Blundell Unit being used for other areas.

We saw two audits by Liverpool Community Health [LCH] for infection control dated 20 April 2015. Blundell unit and Townley had been audited and found 'non-compliant'. We asked what the home had done to address the issues. We were shown two audits carried out by the home [on Townley and Blundell] in February and March 2015 which identified some of the issues and had an action plan attached. Managers were not able to tell us any other follow up since April 2015 in terms of further auditing or whether LCH had been back to audit again. We contacted LCH following inspection who said the home had sent an 'action plan' and were now compliant. Managers stated 'There has been a focus on infection control' but said they would have to send on any further information.

Inadequate

Is the service well-led?

We found the accuracy of contemporaneous person's records on Blundell Unit to be failing in maintaining correct information. The audits used by the managers had not identified this. There were at least four examples of care notes that did not show an updated record of care.

In terms of formal process to get feedback from people and their relatives we were shown the results of last year's relatives' and residents' surveys. This had just been published in May 2015. 'Areas for improvement' on both were 'staff at the home' and 'promptness of staff attending to my relatives needs'. The return for both surveys was very low. We would ask the managers to consider the effectiveness of a survey that only 11 relatives and 16 people in residence for a 180 bedded home had effectively been canvassed for their views and feedback.

This is a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

We found there to be 41 service users with Deprivation of Liberty Safeguard [DoLS] authorisations in place. It is a legal requirement for the Care Quality Commission to be notified of these. No notifications for DOLS had been made to CQC. The question of notification to CQC had been raised by the quality assurance manager on a routine audit and sent to the registered manager on an email on 10 May 2015 but no action had resulted.

These findings were a breach of Regulation 18 of the Health and Social Care Act 2008, Care Quality Commission (Registration) Regulations 2009.

The registered manager explained the companies system of audits from 'house' level to senior management level and how the results of audits were monitored and fed through to higher managers in the company. Any areas for improvement could be picked up and an action plan devised to help ensure continual improvements. We saw audits conducted by senior managers the house managers and Clinical Services Managers [CSM's].

We were able to discuss some of the issues raised on the inspection. For example the staffing issues highlighted were 'not a surprise' for managers as they realised there needed to be action to improve the situation. We also discussed the rise in the death rate over the last few years and managers were able to show how this had been monitored and analysed and the reasons for this [mainly due to the home admitting people for 'end of life' care]. The safeguarding process in place where also well attuned to identifying and monitor any abusive practice in the home. This showed that current processes were picking up and monitoring issues in the home in many instances. We found there to be an issue, however, with the overall culture and processes in the home to fully support key areas of care. On this inspection we identified staffing, maintenance of care records, medicines management as key areas that the current management processes had failed to support.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Peoples health care needs were not consistently monitored effectively which potentially placed people at risk of poor care.**

The enforcement action we took:
We issued an urgent statutory notice requiring the provider not to admit any more people to Stonedale Lodge Residential and Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found some people's care planning had not changed as there are needs had changed. people's care was not planned with respect to people's individual care needs.**

The enforcement action we took:
We issued an urgent statutory notice requiring the provider not to admit any further people to Stonedale Lodge Residential and Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not followed.**

The enforcement action we took:
We issued an urgent statutory notice requiring the provider not to admit any further people to Stonedale Lodge Residential and Nursing Home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems to get feedback from people so that the service could be developed with respect to their needs and wishes needed developing to provide feedback more effectively. There were areas of care management that needed to be improved and these had not always been identified by existing audits and systems in the home.**

The enforcement action we took:
We issued an urgent statutory notice requiring the provider not to admit any further people to Stonedale Lodge Residential and Nursing Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not enough staff on duty at all times to help ensure people were cared for in a safe manner.**

The enforcement action we took:
We issued an urgent statutory notice requiring the provider not to admit any further people to Stonedale Lodge Residential and Nursing Home.