Stone Gables Care Ltd

Stone Gables Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This responsive inspection took place on 14, 15 and 19 December 2017 and was unannounced.

At our last inspection on 13 and 16 March 2016, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff did not receive appropriate supervisions or training in accordance with the provider's policy. At this inspection, we found the service had made improvements in this area. However, we found overall, other elements of the service had deteriorated resulting in three breaches of Regulation.

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. Stone Gables Care Home provides care and support for up to 40 older people. The service provides support for people who may be living with dementia. At the time of our inspection, 34 people were using the service.

The manager of the service was not registered with the Commission at the time of the inspection. However, they had applied and attended an interview to be registered. We will refer to them as the home manager throughout this report. 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.

We found concerns with poor care and support delivery at the home that necessitated a referral to the local authority commissioning and safeguarding team to ensure people's health and wellbeing. These shortfalls had not been identified by the current management team.

The environment of the home was not well maintained, clean or hygienic. We saw furniture was not clean and people were at risk of infection. The registered provider had failed to take action in response to concerns raised about the environment.

Risks to people's health and wellbeing were not always appropriately assessed and reviewed. Care plans were not sufficiently detailed to provide an accurate description of people's care and support needs.

People's health care needs were not consistently assessed, monitored and recorded. People had regular contact with health care professionals however, we saw records were not always updated to reflect this. Referrals to professionals were not always followed up .

Medicines were not always managed safely at the home. People were at risk of not receiving their 'as required' (PRN) medicines when they needed them due to the lack of protocols in place to guide staff.

All staff had completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The home manager had submitted applications to the local authority for all people using the service to lawfully deprive people of their liberty. Assessments of people's mental capacity had not been carried out in relation to their ability to give consent.

We received mixed feedback on the availability of activities. We observed that people living with dementia were at risk of not having their social needs met. We have made a recommendation about this.

Staff were recruited safely with appropriate checks completed to ensure they were suitable to work with vulnerable people. Induction training was completed by staff but this was not based on the Care Certificate. We have made a recommendation about this.

Supervisions were completed regularly. However, none of the staff had had an appraisal. We have made a recommendation about this.

The registered provider had systems in place to seek the views and opinions of people, their relatives and staff. However, they had failed to take action in response to concerns raised.

Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. The lack of effective governance led to people not receiving safe and consistent care.

During this inspection, we found the provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These are Regulation 11 Need for consent, Regulation 12 Safe care and treatment and Regulation 17 Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

The home was not clean, routinely maintained or monitored by the registered provider.

Whilst some people said that they felt safe, we found the home manager did not have effective arrangements to ensure risks were assessed, monitored and mitigated.

Staffing levels had not been determined in line with people's needs. Deployment of staff at meal times required further consideration by the provider. Safe recruitment practices were in place.

Overall people's medicines were safely managed. However, there was a risk that people may not receive 'as required' medicines due to the lack of guidance in place for staff.

Is the service effective?

Requires Improvement

The service was not effective.

People's mental capacity was not considered and the home did not always work in accordance with current legislation.

The design and décor of the building did not take account of the needs of the people who used the service.

The service sought support from external healthcare professionals however, referrals were not always followed up in a timely manner.

Improvements had been made to ensure staff received training and supervision they required for their role.

Is the service caring?

Requires Improvement

The service was not always caring.

There was insufficient evidence to demonstrate that the service

was a caring organisation.

People were not always involved in making decisions about their care.

People's privacy and dignity was supported. Staff treated people with care and kindness. People were able to have friends and relatives visit them when they wished.

Is the service responsive?

Requires Improvement

The service was not responsive.

The provider sought the opinions of people and their relatives however, there was no evidence that this had been used to make improvements to the service.

Care and support was not responsive to people's individual needs. It was not evident people had been involved in planning their care.

People were not always supported to undertake social activities within the home and the wider community.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of managerial oversight of the service as a whole.

The registered provider had not ensured that they operated effective systems and processes to make sure they assessed and monitored their service.

Standards of record keeping were not adequate. This included people's care records and records relating to the management of the service.

Stone Gables Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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 inspection was conducted in response to concerns we had received regarding the standards of cleanliness at the home, the state of repair of the environment of the home, risks to people's health due to poor infection control practices at the home and the poor standard of personal care people were receiving.

This inspection took place on 14, 15 and 19 December 2017 and was unannounced. We visited the home on the first and third day of the inspection. We spoke with the home manager and made requests for information to be sent to us on the second day of the inspection.

The service was inspected by two adult social care inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience with care services for older people and people with dementia.

Before the inspection we reviewed the information we held about the service including the action plan the provider had sent us in response to our last inspection, notifications and information received from the local authority. 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. We also received feedback from a local authority commissioning team and the infection control team who visited the home in response to the concerns we had received.

During the inspection we viewed five staff recruitment files, five people's care records which included risk assessments, care plans, personal care records and medication administration records (MARs). We also looked at records relating to the management of the service which included maintenance and servicing records, complaints, safeguarding and accident and incident records, auditing and monitoring records, and a sample of the provider's policies and procedures.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff.

We spoke with eight people using the service and two people's relatives. We spoke with the registered provider, the home manager and the deputy manager. We also spoke with seven care workers, a member of agency staff, the activities coordinator, the cook and one member of domestic staff.

Requires Improvement

Is the service safe?

Our findings

This inspection was conducted in response to concerns we received regarding the standards of cleanliness and the environment at the home, poor infection control practices and poor standards of personal care. We shared these concerns with the local safeguarding authority and infection control team. This means someone external to the service will also look into these issues.

People said they felt safe as a result of the care and support they received. Comments included; ''It's a nice place. I feel very safe here. I think everything is safe here, I have a key for my room. Staff listen to me,'' and ''I'm very safe here, staff are so good. They have a lot to do, can't expect them to come running in a minute." People's relatives told us, ''Definitely very safe here, never really had any problems. My relative has never had any falls, they are immobile, have to be hoisted everywhere.''

However, our findings did not always support this view. We found a number of areas which demonstrated risks to people's health and wellbeing were not always managed safely. Staff told us that due to poor infection control practices at the home they had experienced diarrhoea. They also said a number of people using the service had experienced diarrhoea, and this was not managed safely. We contacted the infection control team who visited the home and provided guidance for management and staff to follow in the event of an outbreak.

We asked the home manager about the management of infection outbreaks. They told us they could not recall if there had been any outbreaks or who had been affected. During both days of our inspection, we saw there were occasions when staff did not use protective equipment when assisting people to the toilet. We also saw that personal protective equipment such as gloves and aprons was not always available for staff use. The home manager told us they would ensure stocks were replenished.

Care records showed that people had experienced infections which were not always managed effectively. Daily bowel charts in place for one person showed they had been incontinent of faeces for 19 days out of 28. Records showed the person's GP had corresponded with the home regarding the stopping of a medication because of this. The management team told us they did not look at the charts and were not aware of the issues related to this person's health. Records also showed people who had been assessed as being at risk of malnutrition were not receiving the care they needed to prevent deterioration.

We found issues relating to the cleanliness of the home. Furniture and equipment was not clean, hygienic or well maintained. Upholstered chairs in communal areas and people's bedrooms were not clean. Most were badly stained and smelled unpleasant. Some were encrusted with food on the arms and the upholstery of two chairs was torn. We sat in communal areas to speak to people and noted a strong smell of urine. Carpets in the home were very worn and stained and those in the communal areas had dried food in them. The vinyl floor covering in the dining room was very sticky to walk on. The registered provider told us the dining room flooring was to be replaced following our visit. The décor overall was dull and battered with chipped and scratched paintwork. There were areas where the woodwork on the window frames was rotten and flaking.

Cleaning schedules had been updated the week previous to our visit to include furniture, equipment and carpet cleaning. This action was taken following a visit from the infection control team. It was now expected that night staff would complete this cleaning at night.

We spoke with the registered provider about our concerns. We were told new chairs had been ordered for delivery in January 2018. They also told us there was a redecoration plan in place which they would send to us. To date we have not received this. The home manager told us they were not aware of any plans the registered provider had to improve the environment. They said they were using petty cash to make improvements as they did not have an allocated budget for environmental improvements.

Environmental risks were not always safely managed. In one person's room we saw a number of pieces of equipment including a wheelchair, a commode and a walking frame located close to the person's bed. Their care records stated that, 'To maintain a safe environment, all areas should be kept clear of hazards.' We looked at a risk assessment relating to the safe use of equipment. This did not specify which pieces of equipment the person used. Nor did it provide guidance for staff to manage any risks associated with supporting the person to use equipment safely.

People had a red pull cord in their bedrooms which was how they summoned assistance from staff. In one person's room we saw this was located behind them, and tucked behind the headboard of their bed. This meant it was not in their reach. We asked the person how they would seek assistance from staff and they were not aware of the pull cord. They told us they would 'just have to shout'. We were concerned that the person may not receive assistance from staff when they needed it.

All of the above evidence is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to the analysis of accidents and incidents were not detailed. For example, the number of falls was analysed every three months and we saw it had decreased at the following review. However, there was no evidence to demonstrate any actions were taken in response to the analysis.

People had individual Personal Emergency Evacuation Plans (PEEPs) in place on how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose. However, records regarding the business continuity plan for staff to follow in the event of an emergency had not been updated to reflect the current provider and management team of the home.

Arrangements were in place to ensure the safe management of people's medicines. Storage was secure, temperatures checked and stock balances were well managed. Medicines such as controlled drugs which needed additional storage measures were found to be safe and accounted for. Records were comprehensive and well kept. Body maps were used to monitor patches used to administer some types of medicine such as pain relief. Staff were able to tell us about medicines and their side effects and medicines that were time critical to keep people well.

An electronic system was used by staff to record the administration of people's medicines. The system produced a daily report which was reviewed by the management team. They told us they were confident that people received their medicines when they needed them. The electronic system did not include any guidance for staff to follow for people when they were prescribed medicines on an 'as required' basis. Some

of the people who used the service had cognitive impairments which affected their ability to communicate. This meant people were at risk of not receiving their medicines when they needed them due to a lack of appropriate record keeping linked to people's individual medication needs.

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

Staff knew how to identify and raise any concerns about peoples' safety in relation to potential abuse. Staff remained up to date with their knowledge of safeguarding through attending training and refresher courses. Staff had access to safeguarding and whistleblowing procedures to guide their practice.

Most people and their relatives told us that although staff appeared very busy they thought there were enough staff on duty. Comments included; ''Plenty of staff, some people just won't wait. Staff always apologise if they take more than a few minutes to answer,'' ''Staff are very good, they have a lot to do. Can't expect them to come running in a minute,'' and ''Sometimes we don't see many staff at the weekend.''

We visited the home at 7.30pm and found people were either in bed or seated in the communal areas of the home in their night clothes. The senior carer told us most people had requested to go to bed early. We spoke with two people who were in bed but not asleep. Due to their cognitive impairments, they were unable to tell us if they had chosen to go to bed.

We reviewed a handover record from the morning of our visit. It stated a number of people had 'refused' to get up so had remained in bed. One person told us they could go to bed when they wanted but staff were not always available to assist them. They said staff used to get them up very early without asking them. They added that this had changed recently and they now had a lie in. The home manager told us they had carried out three visits to the home at night to review the staffing levels and quality of care. These visits were not recorded. They told us they had no concerns about the care at night in the home. During our inspection we observed care given to people and saw that there were enough staff on duty to meet people's needs. We also reviewed the staffing rotas for the four weeks prior to our inspection. We saw that the manger was flexible with the staffing levels and where people's needs increased, the staffing levels were increased to reflect this. An example of this was where one person had needed to attend a hospital appointment.

We observed the care provided to people throughout our inspection. We saw there were enough staff on duty to support people's needs. We observed people were not waiting for long periods before being attended to. Staff we spoke with gave us mixed feedback about the staffing levels. Some staff said there were not enough, especially at night. Other staff said the home was busy but if staff were organised in how they cared for people there was no problem.

The home manager told us they did not use a tool to calculate the staffing levels. They said they were assured staffing levels were correct as they carried out observations on a daily basis, and had conducted visits to the home at night, to assure themselves. Records relating to these checks had not been made.

We recommend the registered provider implements a tool for the purpose of calculating staffing levels which is based on people's needs.

Recruitment practices were safe. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The home manager told us they had submitted a DoLS application to the local authority for every person using the service. This was because the front door of the home remained locked at all times. However, they told us they had not assessed people's mental capacity in relation to this. The home manager and the deputy manager both confirmed they had not assessed the mental capacity for anyone using the service, and consequently no best interest decision making had taken place (in line with the principals of the MCA), in relation to any decisions about their care. They also confirmed that some people at the home were living with dementia and cognitive impairments that would restrict their abilities to consent to their care and treatment. This placed people at risk of having unnecessary restrictions placed on them and demonstrated that the home manager and registered provider were not acting in line with the requirements of the MCA and associated code of practice.

The home manager told us MCA and DoLS training was covered in staff's induction and updated annually. Records confirmed all staff had completed the training. However, staff we spoke with demonstrated minimal understanding of the principles of the MCA. One member of care staff told us, "It's about asking people before you do things for them." When we asked what they would do if the person refused an aspect of care, the staff member said they were unsure.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in March 2016, we found staff supervisions were not always completed and some staff had not received supervision for over six months. We also found gaps throughout in staff training which included safeguarding and food hygiene. At this inspection, we found the registered provider had taken appropriate action to address previous shortfalls although there were still some minor issues to address. The home manager maintained an up to date training matrix which showed staff had completed training required for their role. Courses included fire safety, infection control, health and safety and first aid. People and their relatives told us they thought staff had received the necessary training to support them. Comments included; ''Staff are well trained, provide a good standard of care,'' ''Staff are skilled, all very good'' and ''Staff are excellent, really look after people.''

Most staff had received regular supervision. The home manager told us they waited until staff had been employed at the home for 12 months before conducting an appraisal. However, none of the staff had received an appraisal of their work performance and some staff had worked at the home for over 12 months.

Staff told us and records showed that they had received induction training. The induction training was not based on the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The induction training in place did not cover the same breadth of training as the Care Certificate requires. It included, managing medicines, fire procedures and Deprivation of Liberty Safeguards (DoLS), with little information about or focus on the individual people using the service and how their personal needs should be met.

We recommend that the registered provider reviews the induction of staff at the home to ensure it meets best practice and includes the Care Certificate and also that they review their system for staff appraisal.

People told us they were happy with the food they were served. People told us; ''Cook goes around every day talking to residents and knows everyone's likes and dislikes,'' ''Food is excellent, it's a varied menu,'' and ''Food's not bad at all. Plenty to eat here, can have snacks through the day, biscuits and pieces of cake.'' We observed the lunchtime meal being served to people, we saw some people had forgotten what they ordered for lunch when they were given their meal. We noticed the menu on display was not clearly written and would therefore not remind people of the food choices each day. We brought this to the attention of the home manager, as this might be helpful for people who were living with dementia.

A number of people did not sit down to eat their meal and despite numerous prompts from staff they left the room. Staff were busy supporting other people to eat their meals so were unable to assist these people and ensure they ate. There were enough staff on duty so people should have been getting the support they needed in a timely manner. We discussed this with the home manager who agreed that they needed to give consideration to whether staff were being deployed effectively.

The service sought advice from other health care professionals to provide input into people's care when they needed it. However, as commented on in the safe section of this report, these referrals were not always followed up if contact was not established by the relevant healthcare professionals. We saw a referral had been made to the dietician for one person in October 2017. The person had not been seen by the dietician at the time of our visit and there were no records to show the home manager or provider had chased this up. The person experienced further weight loss during this time period. The home manager told us they would ensure this was followed up promptly by staff.

The environment at the home was not specifically designed to assist people to orientate themselves, and to meet the needs of people who were living with dementia. For example, the corridors, bedroom doors, and communal areas were not marked with directional signage to assist people to find their way. The home manager told us people did get confused, and sometimes could not find their room. This meant they could enter other people's room by mistake. The home manager told us they were hoping to introduce 'memory boxes' at the home in the near future. These boxes would be located outside people's rooms and contain pictures and items familiar to them, to help identify their room.

We recommend the provider researches best practice guidance in relation to environmental changes that would support people living with dementia.

Requires Improvement

Is the service caring?

Our findings

During the inspection, we observed many instances of kind and compassionate interaction between people and staff. We saw staff knew everyone by name, their likes and dislikes and their preferences when the refreshments trolley came around.

People told us staff supported them to be as independent as they could. Comments included; ''I can't walk, but they help me be as independent as I can,'' ''Staff do anything for me to help me stay as independent as I can, '' and ''Staff listen to my complaints, listen to my happiness. If I'm crying they want to know why. We are like one happy group here.'' One relative told us; ''They help my relative keep on trying to be independent. Staff are most respectful, most compassionate in their care of my relative. They know me by name, we are like family now.''

Every person we spoke with told us staff knew them well and listened to them and supported them in a way they preferred. They said they thought staff were very kind and caring. Comments included; ''Staff here are so obliging, I would give them a brilliant recommendation,'' ''I'm sure they care about me. At night, when I go to bed, I know they look in on me, if they see I'm awake they do 'thumbs up' and ask if I'm okay,'' and ''I never have to wait too long if I ring the bell, they always maintain my dignity.''

We observed good relationships between people and staff, such as staff sharing jokes with people and telling stories about their family. People did not hesitate to request assistance from staff, which indicated they felt safe around staff.

People's dignity and privacy was respected by staff. Staff knocked on people's doors and announced themselves before entering. Care records were kept securely at the home, so that these could only be accessed by authorised people.

There were a number of communal areas, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. This included a conservatory/lounge area and a dining area. People made choices about who visited them at the home and were supported to maintain links with friends and family. One visiting relative told us, "I can visit anytime."

Most staff told us that 'people' made their job enjoyable. One staff member told us, "I really enjoy my role here. I enjoy the interaction with people who live here. Some people are here a long time and we get to know them really well." Another staff member told us, "Things aren't always easy. There are a lot of things that need improving but people make this place a home. We have a lovely group of people here."

We saw a number of notice boards were located around the home. These displayed planned activities for over the Christmas period. Information was posted to advise people where they could get independent support and advice, from an advocacy service for example. On both days of our visit, we saw notice boards in the dining room displayed the wrong day and date. Also, information relating to the menu was not written clearly. We discussed this with the home manager who told us they would ensure this was kept up to date

and appropriate changes made. Having different types of communication such as reminder cards, or a noticeboard telling people the day of the week and time of year available for people would assist people with their short term memory.

The registered provider did not have a procedure in place that described to staff how people could be supported with accessible communication aids. For example, a procedure for staff to follow and consider the use of large print, easy read or pictorial aids if people had communication or visual impairments.

We recommend the registered provider considers and implements an accessible information procedure for staff to follow.

Two visiting relatives told us they had full involvement in developing their relative's care plans. A relative said, ''My relative's care plan is regularly updated and I was fully involved in setting it up'' and ''I was involved in setting a care plan up. It was updated recently." People we spoke with told us they were not sure if they had care plans. Records we reviewed did not show people's care and support was planned in partnership with them and people who were important to them. This may affect staff's ability to deliver person centred care.

Whilst we found that staff were caring in their approach and engagements with people, we could not conclude that the provider was caring because they were not ensuring the service met the requirements of regulations, and we found multiple breaches of regulation at this inspection which put people's health and wellbeing at risk

Requires Improvement

Is the service responsive?

Our findings

Peoples' care records contained outdated paperwork, such as risk assessments and care plans. This made it difficult for staff to access the most current information that was important to the person. The home used standardised care plans for each person however, these were not sufficient or detailed enough to provide individual guidance for staff. For example, the care plan of one person who had dementia stated, they were unable to undertake activities on their own. There was no guidance in place for staff to know when and how often to offer activities. There were no activities listed which the person enjoyed or disliked. This information should have been captured during the assessment process.

We looked at how people's care was evaluated each month. Records showed that evaluations did not always include changes to people's health needs. For example, where one person had been losing weight for a period of four months, the monthly evaluation records stated 'no change'. We spoke with two staff about the person's needs. Only one of them told us that the person had been losing weight. We spoke with the home manager and the deputy manager and showed them the person's care records. They both agreed that the records had not been properly evaluated to reflect changes to the person's needs. This meant staff did not always have up to date information about people's needs. Similarly, advice and treatment from professional visitors such as G.P's and speech and language therapists was included in 'Professional visitor's logs' or letters following visits, but the information was not always added to the care plans.

We found there was a lack of management oversight of staff within the service to ensure that they were following care plans and understood people's changing needs. This meant there was the potential that peoples' current needs had not been identified or met.

The provider had systems in place to seek feedback from people and their relatives but could not demonstrate how this was used to make improvements. The home manager told us an annual satisfaction survey was sent out to people and their relatives. We looked at the most recent survey results which showed 17 people had responded. The main themes were the environment, poor range of activities, staffing levels and personal care needs not always met in a timely manner. There was no action plan in place to show how the registered provider planned to respond and improve the service based on the feedback.

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

We received mixed feedback in relation to people having opportunity to engage in meaningful activities at the home. Some people told us there was always something going on and referred to the activities planned for Christmas that staff had organised. Other people we spoke with told us they did not like group activities and found there was little on offer for them to do. One person told us, "I spend a lot of time in my room. I read or watch TV. I do get bored and would love to get out and about." One relative told us that 'chair exercise' sessions were held weekly and we saw this was advertised in the home. Another person's relative told us that when their relative had moved to the home, they had been told that they would be taken out on trips but this had never happened.

The service employed a dedicated activity coordinator who was observed on the second day of our inspection engaging some people in craft based activities. These included decorating Christmas cakes with people on a one to one basis. A game of bingo was held in the afternoon and attended by 12 people. Most of the people who joined in were mobile and independent. However, we saw there were a number of people living with dementia who were not able to engage. On both days of our visit we saw the same people wandering around the home, in the communal areas and corridors with little engagement from staff. We asked staff on duty if there was anything these people liked to do. The staff said they were not sure but thought that one person liked films. We spoke with the home manager about the provision of activities for people who were living with dementia. They told us this was a work in progress.

We recommend the registered provider reviews the provision of activities within the home to ensure they meet the social needs of all of the people using the service.

People's end of life preferences and choices were not always recorded in their care plans. The home manager told us this was because they chose not to share this information with the service. There was no one receiving end of life care at the time of our visit.

Requires Improvement

Is the service well-led?

Our findings

The provider's website states, 'Our Philosophy of Care at Stone Gables Care Home aims to provide residents with a safe, secure, relaxed and homely environment.' We found that this vision was not demonstrated at the home. We found staff lacked effective leadership and management support and their morale was low.

We found concerns with poor care and support delivery at the home that necessitated a referral to the local authority commissioning safeguarding team to ensure people's health and wellbeing. These shortfalls had not been identified by the current management team.

Staff gave mixed feedback which was mostly negative about working at the home. This related to their frustrations with the lack of action taken by the registered provider in response to concerns they felt they had been encouraged to raise. Staff we spoke with also told us they felt unable to deliver a good standard of care to people at night as the home manager expected them to complete a range of tasks in addition to caring.

Staff told us they were concerned about the environment of the home. Some staff told us they had been ill with infections they believed were related to poor infection control practices. We reported these concerns to the home manager and the registered provider. We were not given any assurances as to how they planned to make improvements. The registered provider told us improvements needed to the environment were included in a refurbishment plan that they would send to us. To date we have not received this.

We identified inconsistencies in the quality of care with documentation and care delivery. For example, we identified some issues with a lack of risk management, the application of the MCA, poor standards of record keeping, a lack of assessment of people's needs and provision of meaningful activities, although we did observe some elements of good practice in these same areas. Therefore, the quality and outcomes for people were inconsistent.

Throughout our visit, when we asked found certain records, these were either not available or did not exist. This meant the registered provider could not provide evidence that they had appropriate governance and oversight procedures in place and could not fully assess the quality and effectiveness of the service. The breaches of regulation we identified had not been prevented through the operation of robust systems to monitor quality and compliance.

We also identified a number of records relating to the health and safety of the service provision which continued to refer to the previous provider of the service. Documents also listed names of people and contact details for people who were no longer involved in the service provision.

Quality assurance audits were carried out but were often routine and were not always followed through. Therefore, they were ineffective and not fit for purpose. For example, we found audits of peoples care records did not include actions for staff to take in order to address any identified shortfalls or dates by which these should be completed. The audit tool itself consisted of a short list of documents and did not

demonstrate how the service was monitoring the quality of the prescribed care. Given our findings relating to aspects of care delivery and records not always being updated to reflect people's current care needs, we judged that the audit system was not robust or effective in addressing areas which required improvement.

Although people's views had been sought these had not been used to improve the quality of care. We saw that a staff survey had also been carried out with a range of concerns expressed. There was no action plan in place to show how these concerns would be addressed and used to improve the service provision.

The home manager showed us minutes of three meetings they had attended with the registered provider. These were dated March, June and July 2017. The minutes showed a number of the issues we had identified were discussed. For example, they noted that improvements were required to the environment of the home and staff morale. The minutes did not offer evidence of any solution and there were no outcomes recorded as to how issues were going to be resolved.

We spoke with the registered provider to inform them of our concerns. They said they knew the governance of the home was not right, and were seeking advice on an appropriate system to use to monitor the quality of the service.

In conclusion, we found the registered provider did not have robust systems and processes in place to enable them to have adequate oversight of the service delivered at Stone Gables Care Home, and this had resulted in a failure to meet relevant regulations. There had also been an absence of formal support and development for the home manager.

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

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not considered people's mental capacity before making applications to the local authority to lawfully deprive them of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not always managed safely. Guidance for staff regarding administration of medicines was not in place. Poor management of infection control meant people were at risk of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that there was a robust quality assurance system in place that enabled them to identify areas that need improvement. They failed to take action when areas of concern were identified. Records were not always updated to reflect people's current care needs. Records relating to the management of the service were not up to date.