Advinia Care Homes Limited

Stonedale Lodge Care Home

Inspection report

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Liverpool
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Stonedale Lodge Care Home is a residential care and nursing home in the Croxteth area of Liverpool, providing personal and nursing care to people aged 65 and over. The service can support up to 180 people across six units, each specialising in either residential or nursing care for older people, including those living with dementia. At the time of our inspection there were 140 people using the service.

People's experience of using this service and what we found
Inadequate governance and quality assurance measures meant that people were exposed to unnecessary risk and avoidable harm. There has been repeated failure from the provider to ensure the delivery of safe, high quality care.

People were exposed to risk of harm as their care needs and associated risks had not been managed appropriately. Risk assessments were either not reflective of people's current needs or detailed enough to guide staff on safely supporting people.

Accident and incident processes were inadequate. The service did not look for safety related themes and trends reliably and robustly. There was little evidence of learning from events or action taken to improve safety.

People were at risk because measures to prevent and control the spread of infection were ineffective.

There were not enough suitably qualified staff to support people. Records showed actual staffing levels had fallen below assessed safe staffing numbers placing people at risk of unsafe care.

People's privacy was not always respected. The provider had neglected to adequately maintain the environment in two of the units and this meant people were living in undignified conditions.

Staff did not feel that their feedback was used to improve the service, and some told us that management did not respond appropriately to the concerns they raised.

Safeguarding systems and policies were in place and staff could describe the action they would take if they felt people were at risk of abuse. The registered manager understood their duty to share information in an open and honest manner.

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

Overall medicines were safely managed. The service was working alongside the local authority medicines

management team to roll out a consistent system across the whole home.

Staff approached people well and were generally being attentive to their needs. However, many interactions were task orientated. People told us that staff treated them with kindness and respect.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 October 2020).

At our last inspection we made recommendations for the provider to review the quality and consistency of information in people's care records, staff planning and deployment and to ensure improvement plans were acted upon so actions relating to people's safety were addressed quickly and effectively. At this inspection we found the provider had not effectively acted upon recommendations and the provider was in breach of regulations.

Why we inspected
We received concerns in relation to risk management and an increase to the number of accidents and incidents that were occurring in the home. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. Due to concerns we identified on the first day of the inspection, a decision was made to widen the inspection to include the key question of caring.

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, privacy and dignity and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

Follow up

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Stonedale Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stonedale Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stonedale Lodge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 July 2022 and ended on 18 July 2022. We visited the service on 7 and 14 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 17 members of staff including the registered manager, regional director, unit managers, senior care staff, registered nurses and care staff. We spoke with nine people and five relatives about their experiences of care their loved ones received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records including 22 people's care records, multiple medication administration records, and five staff personnel files in relation to recruitment. We also reviewed a variety of records relating to the management and governance of the service, including policies and procedures.

After the inspection, we continued to review evidence that was sent remotely as well as seeking clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures. We also informed the local authority of the concerns and areas of risk we identified and shared information about risk to individuals with the local safeguarding team.

Inadequate

Is the service safe?

Our findings

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

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

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

- People were exposed to risk of harm as their care needs and associated risks had not been managed appropriately.
- Risk assessments were either not reflective of people's current needs or detailed enough to guide staff on safely supporting people.
- When risks were identified, staff did not always adhere to the control measures to keep people safe. For example, one person's care plan stated they should be observed closely by staff as they were at risk of absconding and were verbally and physically aggressive towards others. Records showed this person was involved in multiple incidents involving people and staff. Our observations found that this person was regularly unsupervised which placed them and others at risk of avoidable harm.
- Accident and incident processes were inadequate. The service did not look for safety related themes and trends reliably and robustly. There was little evidence of learning from events or action taken to improve safety. For example, we found that there was limited action taken when people experienced multiple falls. This meant people were at risk of further falls and this placed them at an increased risk of harm.

The lack of effective systems to identify and monitor risk and do all that is reasonably practicable to reduce the likelihood of harm was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider took steps to update care plans to ensure they reflected people's current needs and risks and took action to improve accidents and incident recording and analysis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection
● People were at risk because measures to prevent and control the spread of infection were ineffective.
● The internal environment was poorly maintained, and we found multiple unclean areas such as toilets, bathtubs, chairs and door frames. There were strong malodours on two of the units.
● The process for prioritising unclean areas was ineffective. For example, during our late morning observations, we found one person's room had not been cleaned and was cluttered with used paper towels and the bed linen and chair was soiled with faeces. This issue had not been raised with domestic staff. We raised our concerns with the local authority infection prevention and control team.

The failure to manage risks related to the spread of infection is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● There were not enough suitably qualified staff to support people.
● Our observations found people were left unsupported for extended periods of time. This was in contradiction to their assessed needs and their care plan.
● Systems were in place to determine how many staff were needed to safely care for people and meet their needs. However, records showed actual staffing levels had fallen below assessed safe staffing numbers on multiple occasions placing people at risk of unsafe care.
● Staff told us staffing levels were unsafe. Comments included, "Staffing levels are too low. People are at risk" and "residents are getting neglected, if we had the right amount of staff, it would be ok, but people's safety is at risk as it stands. I take worries home."

There were not enough suitably qualified, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately and took action to ensure staffing levels were safe.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and policies were in place and staff could describe the action they would take if they felt people were at risk of abuse.
● Due to recording issues in relation to accidents and incidents, we could not be sure that all safeguarding referrals had been made to the Local authority.

Using medicines safely
● Overall medicines were safely managed.
● We found some inconsistencies with ordering and stock management across the units. However, the service was working alongside the local authority medicines management team to roll out a consistent system.
● When people required medicines on an 'as and when required' basis to help manage periods of emotional distress, care plans did not contain sufficient information to guide staff on what measures should be tried first to avoid overuse of medicines. The provider acted upon our feedback and committed to reviewing all protocols for 'as and when required' medicines.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
- People's privacy was not always respected.
- Staff did not always see people's privacy and dignity as a priority and failed to take action to ensure people's private space and possessions were respected.
- People and relatives told us that other people regularly came into their rooms uninvited. Our observations across both days of the inspection confirmed this.
- We observed one person barricading their bedroom door with a chair to prevent others coming in and using a piece of gauze on the door handle, so they knew if someone had been in their room. The person told us," I drag the chair in front of the doors as [person] walks in if the door is open, I don't feel safe, I feel isolated and vulnerable. Anything could happen to you here and no-one would know."
- The provider had neglected to adequately maintain the environment in two of the units and this meant people were living in undignified conditions. For example, we found that many bedrooms and communal areas had damaged furniture.

The failure to ensure people were treated with dignity and respect was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to better promote people's privacy such as installing locks on doors and put immediate plans in place to improve people's living conditions.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
- Staff approached people well and were generally being attentive to their needs. However, many interactions were task orientated and staff did not sit and talk to people for a meaningful amount of time.
- Records did not always demonstrate people were involved when changes to their care plan were made.
- People told us that staff treated them with kindness and respect. Comments included, "the staff are very good, the care is very good, if I'm worried about something I can always talk to them", "The staff are all very caring and thoughtful, I get treated very nicely by the staff" and "it's like a family here."

Inadequate

Is the service well-led?

Our findings

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

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

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

- Inadequate governance and quality assurance measures meant that people were exposed to unnecessary risk and avoidable harm. The provider was not assessing, monitoring or mitigating risk relating to the health, safety and well-being of the people living at the home.
- There has been repeated failure from the provider to ensure the delivery of safe, high quality care. Multiple breaches of regulation meant the provider was not clear about their role and regulatory responsibilities and was unable to demonstrate their compliance with the fundamental standards.
- Monitoring systems failed to identify all shortfalls found with risk assessments, staffing, infection control and maintaining people's dignity found during this inspection. This meant opportunities to drive improvements to quality and safety were missed.
- Environmental improvement plans had been discussed at previous inspections. However, we found a sustained lack of action to improve people's living conditions.
- Accident and incident processes were inadequate. Reporting of incidents, risks, issues and concerns was unreliable and inconsistent. This meant the registered manager had ineffective oversight of concerns.
- Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.

The provider failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider submitted an action plan to demonstrate how they were improving their systems to mitigate risk and protect people from harm.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager understood their duty to share information in an open and honest manner. However, due to gaps found with accident and incident reporting, we could not be sure that all relevant people had been notified of safety related incidents in a timely manner.
- Staff did not feel that their feedback was used to improve the service, and some told us that management

did not respond appropriately to the concerns they raised.
● The local authority and social worker provided positive feedback about working in partnership with the home. However, some concerns were shared about lack of communication between the unit managers and the registered manager. Our findings confirmed this.

Working in partnership with others
● The local authority and social worker provided positive feedback about working in partnership with the home. However, some concerns were shared about lack of communication between the unit managers and the registered manager. Our findings confirmed this.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not always respected. Staff did not always see people's privacy and dignity as a priority and failed to take action to ensure people's private space and possessions were respected. The provider had neglected to adequately maintain the environment and people were living in undignified conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate governance and quality assurance measures meant that people were exposed to unnecessary risk and avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably qualified staff to support people safely.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to implement effective systems to identify and monitor risk and do all that is reasonably practicable to reduce the likelihood of harm. Accident and incident processes were inadequate. There was little evidence of learning from events or action taken to improve people's safety.

The enforcement action we took:

warning notice