Mr & Mrs R Cowen

Stonehaven Residential Home

Inspection report

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Date of inspection visit: 11 & 17 August 2015
Date of publication: 26/10/2015

Ratings

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

Overall summary

This inspection took place on 11 and 17 August 2015 and was unannounced. The service provides accommodation and personal care for up to 27 people, including people living with dementia. It also provides short-term respite care for people. There were 16 people living at the service when we visited.

At our last inspection, on 28 November and 1 December 2014 we identified breaches of seven regulations. We issued three warning notices and four requirement notices. The provider wrote to us telling us they would take action to become compliant with all regulations by 14 May 2015.

At this inspection we found some improvements had been made, but the provider was still not meeting all fundamental standards of quality and safety.

The home had a registered manager in place. A registered manager is a person who has registered with the Care

Summary of findings

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.

People's safety was compromised in some areas. Infection control guidance was not always followed by staff operating the laundry. Disposable gloves and aprons were not available in the laundry. The laundry and medicines rooms were not clean and some areas of the home smelt of urine.

One person told us two staff members mistreated them. This led to the provider taking disciplinary action against two senior staff members for abuse. However, prompt action was not taken when the person reported a lost watch. We observed a range of interactions between people and staff, some of which were patient and caring and some of which showed a lack of consideration.

There were not always enough staff available to meet people's needs and staff were not organised well. The staff member administering medicines was interrupted seven times to support people or other staff. This increased the risks of making mistakes with people's medicines and a delay in people receiving their medicines.

We received mixed views from people about the quality of the food. A range of drinks was available throughout the day, although only water was available at lunchtime. The service of meals was disorganised and people did not receive appropriate support to encourage them to eat well. Accurate records of people's food and fluid intake were not maintained.

Staff did not follow legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests. However, they did follow legislation to make sure people were not deprived of their liberty unlawfully.

New members of staff did not always receive appropriate supervision or support. There was no effective process in place to make sure staff were competent before being allowed to work unsupervised. Experienced care staff received appropriate training, supervision and appraisal, although some senior staff were critical of the preparation they received for their role. Non-care staff were not trained or skilled at communicating with older people or people with dementia care needs. They did not receive supervision or appraisal to assess their performance or their training needs

Sedatives were not always administered appropriately. Alternative, more suitable strategies to support people when they became anxious were not always used. Charts designed to help identify triggers that caused people to become agitated were not always completed by staff so that appropriate strategies to support people could be developed.

Care plans did not contain sufficient guidance about the support people needed to maintain healthy skin, to regain their mobility after surgery or to support them when they experienced seizures.

Activities were provided, including events to which family members were invited. However, these were limited to times when the activity coordinator was working.

The provider conducted a range of audits. The medicines audit had been effective in ensuring compliance with the regulation, but the audit of infection control procedures and reviews of care plans had not picked up the concerns we identified.

Some staff described management as "supportive" and "approachable", but others described a culture of blame and bullying. There was high turnover of care staff, including three members of staff who had been dismissed for misconduct. As a consequence, people did not receive care from a motivated, consistent staff team.

However, most people and their relatives told us they were satisfied with care provided. A clear management structure was in place and relatives felt the home was run well. Family members were welcomed and described the home as "homely".

Some aspects of care planning had improved, including information about people's continence needs and pain management. A compliance manager had been employed to improve quality assurance arrangements.

Risks posed by the environment were managed effectively. Recruiting practices were safe. Suitable arrangements were in place to manage medicines safely. Staff knew what action to take if the fire alarm activated.

Summary of findings

People were involved in discussing and planning their care and treatment. The provider had appropriate policies in place to protect people's privacy.

Following the inspection we discussed our concerns with the Isle of Wight Council's safeguarding adults team.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the enforcement action we have taken at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

Staff did not always follow infection control guidance and some areas of the home were not clean. Two people were mistreated by senior staff. Prompt action was not taken when a person reported a lost watch.

There were not always enough staff deployed to meet people's needs and staff were disorganised. The risks of people developing pressure injuries were not always managed effectively.

Medicines were managed safely. Recruitment practices were safe and appropriate emergency procedures were in place.

Is the service effective?

Inadequate

The service was not always effective.

People did not always receive appropriate support to eat and drink. Food and fluid charts were not accurate. New staff did not always receive appropriate support.

Staff did not follow legislation designed to protect people's rights when people were unable to make certain decisions. Staff did not always receive appropriate support to carry out their work.

People were only deprived of their liberty where legal authority had been given. Established staff received appropriate training which was refreshed regularly. People were able to access healthcare advice when needed.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always treated with consideration.

Some experienced staff were skilled at communicating with people living with dementia, understood their needs and were patient and kind. Staff respected people's privacy.

People and their relatives (where appropriate) were involved in planning their care.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

Suitable strategies to support people who became anxious were not always used prior to sedatives being administered. Charts to record why sedatives were given were not always completed.

Summary of findings

Care plans to develop a person's mobility and support a person when they had seizures did not contain sufficient information. Activity provision was limited and not always appropriate for people with cognitive impairment.

Most people were satisfied with the care they received. Care plans were reviewed regularly and contained information to allow staff to support people appropriately with their continence and pain management.

Is the service well-led?

Inadequate

The service was not well-led.

Staff were task orientated and not well organised. The culture of the service did not support or encourage staff to provide compassionate, high quality care.

There was a high turnover of staff, including three staff members who had been dismissed. The relationship with the community nursing team had broken down.

Quality assurance systems were not effective as breaches of five regulations were identified. Not all concerns identified at the last inspection had been addressed.

There was a clear management structure in place. Family members and most people praised the management of the home. A compliance manager had been employed to improve quality assurance arrangements.

Stonehaven Residential 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 took place on 11 and 17 August 2015 and was unannounced. The inspection team consisted of an inspector, a specialist advisor in the care of older people and an expert by experience in dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people using the service and five family members. We also spoke with the registered manager, the deputy care manager, nine care staff, the activity coordinator, the cook and the cleaner. We also spoke with three healthcare professionals and staff from the local authority commissioning team. We looked at care plans and associated records for seven people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection on 28 November and 1 December 2014, we identified there were not enough staff to meet people's needs; medicines were not managed safely and risks to people were not managed effectively. At this inspection we found the concerns relating to medicines had been addressed. Staffing concerns had not been addressed and we identified new concerns relating to risks to people and infection control arrangements.

Infection risks had been assessed and measures put in place to control the risks. These included regular staff training and schedule of cleaning. However, we found staff did not always follow best practice guidance. The laundry had a hand washing sink so staff could clean their hands after handling soiled linen, but we saw this had not been used. Paper towels for drying hands were not available. The person who operated the laundry on one day told us they had used an alternative sink to wash their hands. The sink they described was in a bathroom some way away from the laundry and the person had to walk through a hallway and two lounges to reach it. This posed a risk of cross infection had they touched anything or anyone on the way to it. There was no personal protective equipment (PPE), such as disposable gloves or aprons available in the laundry. Staff told us they had to get these from the same bathroom before operating the laundry. The lack of readily available PPE did not promote good hygiene practices.

Staff put soiled linen into red, soluble bags which could be placed directly into washing machines. In the laundry, they were initially placed into a red laundry bin to keep them separate from other washing. However, we saw other clothing, not in bags had been placed on top of red bags in this bin. This posed a risk of cross contamination. The area behind the washings machines in the laundry room was not clean and items of clothing had fallen behind the machines. There was a cleaning schedule for cleaning the laundry and the sluice room, but check sheets had not been completed since March 2015, so the provider was unable to confirm when they had last been cleaned. No instructions were available to advise staff which washing machine programmes to use. When we asked three members of staff which programme they used for washing soiled linen and each gave a different answer. Two of the answers indicated temperatures that were too low to clean potentially infected linen safely.

There was no cleaning schedule in place for the medicines room. We found three discarded tablets under the fridge and the area was not clean. The provider was not able to tell us when the room had last been cleaned. Two people needed to use a hoist to transfer onto and off the toilet and between their beds and chairs. Staff told us that both people shared one hoist sling. This posed a risk of cross contamination between people. The flooring of the ground floor toilet was torn along one edge and starting to lift from around the base of the toilet pan. These areas created bacteria traps and posed an infection risk. When a staff member spilt a drink on the carpet in the lounge, no attempt was made to clean it.

Some areas of the home smelt of urine. This was noticeable at the back of the main lounge and in the hallway at times. The mattresses in two people's rooms also smelt of urine. When we pointed this out to staff, the mattresses were replaced. Visiting healthcare professionals also told us the home often smelt of urine.

The failure to manage infection risks effectively was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave us mixed views about staffing arrangements. One family member told us, "Staff are always available, walking through the lounge and sit in there to write reports." However, other people told us staff were not always available or sufficiently experienced to meet their needs. One person said, "On occasions there is not one member of staff in the big lounge, particularly at mealtimes." They added that the home was "generally understaffed". A family member told us "There are hardly enough staff. Recently there have been big changes of staff. It is a job to tell if they are trained when they are all new."

Our observations confirmed there were not always enough staff available to meet people's needs. Before lunch on the first day of our inspection three people had to wait to use the bathroom as there were not enough staff to support all those people who required assistance. One person had to wait for 11 minutes, which caused them to become distressed. On the second day of our inspection, we saw there were no staff supervising people eating their breakfast in the dining room. One person was calling out "Help, help I need the toilet" while attempting to stand. Shortly afterwards a staff member arrived and supported the person to walk to the bathroom. Five minutes later, we heard the person calling out from the bathroom for help to

Is the service safe?

re-dress themselves. No staff member was nearby, so we went and found one to assist the person. Later we saw a person coming out of the bathroom on their own. They were walking very unsteadily and were holding a large quantity of toilet paper in their hands. There were no staff nearby and they were at high risk of falling, having only recently returned to the home after surgery. A staff member who was undertaking the medicines round stopped the round to help the person. We had to call staff twice more to assist this person when they were again at risk of falling. The staff member administering medicines was interrupted seven times to divert to other tasks, including attending to a person whose call bell had been ringing for four minutes. Interruptions during the medicines round increases the risk of mistakes, delay people receiving their medicines and are contrary to best practice guidance. Staff were not deployed in a way that met people's needs.

The registered manager determined staffing levels by assessing people's needs and seeking feedback from staff and people. They had access to a staff planning tool which required data to be added to a spreadsheet to help assess staffing needs, but were not using it. The registered manager told us staffing numbers were based on a senior member of care staff plus three care staff throughout the day and two care staff during the night. However, duty rosters for the weeks of our inspection showed there were times when only a senior and two care staff were working, one of whom was sometimes a new member of staff who lacked the skills or experience to work unsupervised. The shortages of staff we observed during the inspection occurred at times when there was one senior and two care staff available to support people. This level of staffing was not adequate then, so would not be adequate on other days either.

The continued failure to ensure there were enough staff available to meet people's needs in a timely way was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of developing pressure injuries. Assessments of the risk of people developing pressure injuries and skin damage were completed using a recognised tool. These had led to the use of pressure relieving equipment, such as cushions and mattresses being put in place for people who needed them. However, three care plans did not contain sufficient guidance about other support people needed to maintain healthy skin, such as how affected skin should be cleaned, the use of moisture or protection products and the need to ensure continence products were changed regularly. One person was receiving treatment from community healthcare professionals for a sacral sore, for which the healthcare professionals kept their own records. The person's care plan did not contain information about the care required from staff at the home to look after the surrounding skin. Healthcare professionals expressed concerns about the way this person's injury was being managed by the home. They told us charts used to record when the person had been supported to re-position in bed and records of the person's food and fluid intake were not completed fully or accurately.

The failure to ensure care and treatment was provided in a safe way and to reduce the risks to people's health was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they did not always feel safe at the home. They said, "I feel safe half the time, depending upon who is on duty". They said there were two members of staff who "shout, scream and swear. They are very rough with residents." The person subsequently made a complaint to the provider about the relevant staff members. The provider investigated the allegations and took disciplinary action against the two senior staff members involved. The investigation revealed that a second person had also been abused. Both incidents were reported to the safeguarding authority in accordance with local protocols.

Prompt action was not taken when the same person reported that their watch had been lost. They told us "The care home said they would deal with it but they have done nothing". The person's care records showed they had raised the concern about their watch five weeks previously, but the provider had not taken action to investigate the loss. We raised this with the registered manager, who then commenced an investigation. We were later informed that the watch had been found in the person's room.

Other people, and their relatives, told us they felt safe at the home. One person said, "I would rather be at home but I feel safe here because it is homely and there is everyone around you." A family member told us, "I feel at ease that [my relative] is there. She is safe."

We also saw people being encouraged to use walking aids safely, although these were not marked with people's

Inadequate

Is the service safe?

names, so there was a risk people would use frames which were not set at the right size for them. We observed five moving and handling procedures which were managed competently. When staff used hoists and stand-aids, they did so in pairs and in accordance with best practice guidance. Risks posed by the environment were assessed and managed effectively. These included alarms to alert staff if people opened fire escapes, restrictors on upper windows to prevent people falling and regular checks of hot water temperatures, including before people were assisted with baths.

Appropriate arrangements were in place for obtaining, storing, recording and disposing of prescribed medicines. Medication administration records (MAR) confirmed people had received their regular medicines as prescribed. Medicine audits were carried out monthly together with a weekly medicines count to check that stock levels were accurate. A new medicines fridge had been installed since our last inspection. Staff were suitably trained and had been assessed as competent to administer medicines.

The process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm activated, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. People had personal evacuation plans in place detailing the support they would need in an emergency.

Inadequate

Is the service effective?

Our findings

At our last inspection on 28 November and 1 December 2014, we identified that the amount people ate and drank was not monitored effectively. Staff were not trained in managing behaviour that challenged staff. Staff did not follow the law when assessing people's ability to make decisions. At this inspection we found these concerns had not been addressed fully.

Some of the people using the service had cognitive impairment. Staff had received training in the Mental Capacity Act, 2005 (MCA), but did not always follow its principles. The MCA aims to protect the rights of people who lack capacity, and maximise their ability to make decisions or participate in decisions that affect them. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Since the last inspection, the provider had introduced MCA assessment forms. These were used to identify which decisions the person was able to make. The MCA is clear that mental capacity assessments should be decision specific. However the structure of the form, which involved a tick box approach to a range of issues, was not decision specific, which meant it would not have helped staff to make correct assessments.

Where people were assessed as unable to make one of the decisions listed on the form, best interest decisions were not always recorded. Where decisions had been made on behalf of people, there was no record to show that family members or professionals had been consulted. These included decisions relating to the use of lap belts on wheelchairs, bed rails; the administration of medicines and the delivery of personal care. In one case, a person had been assessed as unable to make food choices. Their care plan instructed staff to make best interest decisions on behalf of the person. However, the care plan did not suggest ways that staff could support the person to make these decisions, for example by presenting alternative options to them at the table or showing them pictures of each meal. The MCA was therefore not being followed and people's rights were not protected.

The continued failure to ensure that people were supported to make decisions, and that decisions were made in people's best interests, was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's care records showed a relative had been appointed to make decisions on their behalf and their care plan contained the legal authority confirming this. Reviews had been held with the appointed person to help ensure the person's rights and wishes were met.

The service had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. A DoLS authorisation was in place for one person and applications had been made for 10 other people. Staff knew about this and the support the person needed as a consequence.

New members of staff did not always receive appropriate supervision or support. We observed a member of staff who was new to the home and had not worked in care before was not supervised directly. They were left to try and support people on their own. They did not engage with people or respond to their needs appropriately. For example, when a person told them they felt cold the new staff member felt their hand and said, "Well you don't feel cold to me." On another occasion, while supporting a person to transfer from their wheelchair to an armchair they did not apply the wheelchair brakes. The wheelchair moved and knocked the person on the ankle causing their soft ankle boot to be knocked off. The staff member's training had comprised viewing videos and completing workbooks relating to topics including moving and handling, fire safety, food safety and infection control. However, this training was not sufficient, without guidance and supervision for them to be able to perform their role effectively.

The provider told us new staff worked with experienced staff "until we see what they are like". They said they worked as an additional member of staff on shift "unless someone goes sick, then it's unavoidable". There was not a clear policy in place to ensure staff who were new to care work were appropriately supervised until they had been assessed as competent to work unsupervised.

Inadequate

Is the service effective?

Whilst some experienced staff felt equipped for their role, others felt they needed additional support and training. For example, one staff member who had recently been promoted to senior carer told us "I did extra training for medicines and [the deputy head of care] went through everything we need to do, like oxygen machines, daily records, charts, fire procedures, evacuation, hospital admission forms. I went to college to do a few courses and am now on an NVQ 3." However, another staff member said, "I haven't done as much training as I need to but am going to and we're sorting that out." A third staff member told us they were not suitably trained when they were promoted to senior. They said, "I wasn't qualified and had no experience for role. I was thrown in the deep end".

Non-care staff were not trained or skilled in communicating with older people or people living with dementia. During the morning, the cook asked people individually for their choice of lunchtime and evening meals. They asked people to choose between two main meals, two desserts and two evening meals by posing a series of questions one after another. This confused some people, including one person who told the cook, "You're getting me mixed up now because the meals and choices are all mixed up." Some people responded by simply choosing the last option given. As a consequence, there was a risk that people may not have received their preferred option.

The failure to ensure staff received appropriate support and training for their roles was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff told us they received regular one-to-one sessions of supervision. Sessions of supervision provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Records showed these meetings were used to discuss staff development and training needs. Care staff who had worked at the home for more than a year also received an annual appraisal to assess their performance. However, non-care staff, such as the cook and the cleaner did not receive supervision or appraisal, so their professional development may not have been considered.

Established staff had received a wide range of training, which was refreshed regularly. This included safeguarding adults, moving and handling, infection control, dementia and fire safety. The provider also supported and encouraged staff to undertake vocational qualifications.

People's food and fluid intake was monitored using charts. However, the charts were not always accurate. We checked the charts for a person who we observed had not eaten their main course, but had eaten two desserts. We found staff had recorded that the person had eaten most of their main course and one dessert. The person's fluid intake for a six day period was not completed fully on two of the days. When the charts were completed, they showed the person had not been offered anything to drink from 17:30 most evenings until 08:30 the following mornings. This meant the provider was unable to confirm that people had drunk enough. The target amount for people to drink was not personalised and was shown as 1,600mls for females and 2,000mls for males, irrespective of their individual weight. This was contrary to guidance issued by the national Institute for Health and Clinical Excellence (NICE), which recommends that a person's fluid intake should be based on a number of factors, including the person's weight. A community healthcare professional expressed concerns about the hydration levels of a person receiving end of life care and told us the person's fluid records were not always accurate or fully completed. When we checked the person's fluid record charts we confirmed they had not been completed fully. At 3:00pm in the afternoon, no fluids had been recorded as offered or consumed that day. No output had been recorded from the person's catheter bag for that day or for the previous two days. The failure to monitor and record people's fluid intake accurately put them at risk of dehydration.

The failure to keep accurate records of people's food and fluid intake was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about the quality of the food and drink people received. One person said "The food is good and there is choice." A family member said, "[My relative] eats well and says the food is lovely. They haven't lost any weight." However, one person told us "The food is not well

Is the service effective?

balanced; there is a lot of carbohydrate" and another person described the food as "monotonous". A staff member said, I think the menu needs refreshing as people get bored with it."

People's nutritional needs were assessed and they were offered a choice of suitable meals. However, the service of meals was disorganised and people did not always receive appropriate support. Although people were brought to the tables at the same time, they received their meals at different times. Some did not receive their main course until others had finished theirs. Desserts arrived before some people had finished their main course, so would have been cold by the time they ate them. One person sent their main meal back because it was cold and were given an alternative meal; a second person also said their meal was cold. People who needed support to eat received it, but not in an effective or dignified way. Most staff stood up while supporting people to eat. One staff member sat down to help a person to eat while at the same time cutting up another person's food for them. Having supported the person with their main course, the staff member moved away and a second member of staff assisted the person with a drink. Later, a third staff member supported the person to eat their dessert. Other people also experienced inconsistent support from staff.

The lack of organisation did not create a pleasant experience for people or encourage them to eat well. We noted that people were only offered water to drink at lunchtime, with no alternative being offered. Some people drank very little of this and only one person asked for a second glass. Jugs of water or juices, to encourage people to drink, were not available in the dining room. However, they were available in the lounges and we heard people being encouraged to drink.

People had appropriate access to doctors, who visited regularly. A family member told us their relative "wasn't well a few weeks ago. [The deputy head of care] spoke with the GP and changed [their] medicines to liquid form and they are working better for [them] now". Care records showed involvement by community healthcare specialists such as nurses, chiropodists, opticians, and psychiatrists. Two people had been identified by staff as at risk of choking on their food. Staff had referred these people to a specialist so their needs could be assessed fully and appropriate guidance given.

Requires improvement

Is the service caring?

Our findings

At our last inspection on 28 November and 1 December 2014, we identified that people were not always treated with consideration and respect. At this inspection one person told us this was still the case. They said two staff members treated them "roughly", were "rude" and "very fond of their own self- importance". However, they said another member of staff was "very thoughtful, caring and helpful".

We observed a range of interactions between people and staff, some of which were positive and some of which were not positive. For example, when a person said they were cold, a staff member got a blanket for them and closed the window near them. However, when another person said they had cold feet, staff did not act in a caring way. A staff member got the person's socks; but they would not fit and were taken away. No other attempt was made to warm or cover the person's feet. Without explanation or warning, a staff member removed a person's blanket while they were sat in a chair and told the person to "wait" while they got the person's walking frame to take them to lunch. This did not show consideration for the person.

More experienced members of staff were skilled at communicating with people living with dementia. At lunchtime, a staff member took time to help a person position their hands so they could hold their knife and fork. They then engaged them in conversation about the person's previous job. When the person dropped their fork, they were given a clean one. After a game of bingo, they offered to take the person's cup of tea through to the lounge where they usually sat.

Some experienced staff knew people well and were patient and kind towards them. They had a good understanding of people's needs and responded with warmth and appropriate humour. When a person asked when a family member was next visiting, the staff member said, "Your [family member] visits on a Friday; today is Tuesday, so it will be three days when she visits you again." When another person was becoming agitated at lunchtime, the staff member reassured other people who were concerned about the person. They did this calmly and effectively. Frowns of concern turned to smiles of relief and one of them said, "You're a very good carer."

When a person was unsettled in their chair, the staff member recognised they were not comfortable and offered the person a cushion. "Oh I'd love one" the person replied. The cushion was provided and the staff member took time to adjust it until they were comfortable. To encourage a person who was at risk of falling to stay safe in their chair, a staff member offered to take them into the garden to feed the birds once the medicines round was over. Although it took two hours to complete the round, the staff member did not forget their commitment to the person and took them to the garden to feed the birds. When attending to a person who was very unwell, a staff member spoke with the person in a kind and non-patronising manner. They clearly knew the person and their interests and there was a good rapport between them. The staff member provided treatment and, at the same time, reassurance through their conversation and manner with the person.

Staff spoke enthusiastically about two people who had formed a good friendship since moving to the home. At lunchtime, they made sure they were able to sit together. A staff member told us, "It's lovely to see them together. [The one person] eats so much better when [the other person] is with them.

When staff assisted people to move using equipment, such as a hoist or stand-aid, we observed they communicated with the person throughout. They told them what was happening, how long it would take and reassured them they were safe. A family member told us staff were "very good at transferring [my relative] from her wheelchair. They're patient with her".

The provider had appropriate policies in place to protect people's privacy. Staff were able to tell us the practical steps they took to ensure people's privacy was not compromised. These included knocking and waiting for a response before entering people's rooms and ensuring doors were closed when providing personal care. We saw staff followed these steps at all times. All bedrooms had locks and people were able to request a key and use the locks if they wished to; staff had access to a master key to use in an emergency. Confidential records were held securely and only staff who needed to view them were able to.

Comments in care plans and reviews of people's care showed they, and their relatives, were involved in discussing and planning their care and treatment. People's preferences, likes and dislikes were recorded in care plans,

Requires improvement

Is the service caring?

and support was provided in accordance with people's wishes. These included people's preferred times for getting up and going to bed. People were also able to specify whether they preferred a male or a female staff member to support them with certain aspects of their care and we saw these preferences were respected.

Requires improvement

Is the service responsive?

Our findings

At the last inspection, on 28 November and 1 December 2014, we identified that staff had not received training in supporting people who behaved in a way that challenged staff and care plans did not provide adequate guidance. At this inspection we found guidance in care plans had improved, but staff had still not received training in this area and did not always follow people's care plans or the provider's procedures.

People were not always given appropriate support when they became anxious or agitated. Some staff administered sedatives to people before trying other, more suitable, strategies to support people first. We looked at the care records and medication administration records (MAR) for three people whose needs caused them to behave in a way that challenged staff. Two people had been assessed by a specialist who had provided advice on strategies that might help when they became agitated or distressed. These included the use of calming music and sensory based activities. In addition, a sedative had been prescribed on a 'when required' (PRN) basis for when these strategies did not work. The deputy head of care told us sedatives were only used "as a last resort". However, guidance to staff on when to administer sedatives to people was not detailed. It did not explain when, in what circumstances and what dose they should be given, or what strategies should be tried first. We drew this to the attention of the head of care and by the end of the inspection they had amended the guidance to make it clearer. The care plan for one person showed their care had been discussed with a family member in January 2015 and staff had agreed to try using 'dancing light' therapy and music when the person became agitated. Records showed these therapies had been successful in calming the person on three occasions. However, on five subsequent occasions the person had been given a sedative and there was no evidence to show that staff had tried using the agreed therapies first.

The provider's policy required staff to use 'behaviour charts' to record people's behaviour when sedatives needed to be given, but staff did not always complete these. These were designed to help identify triggers that caused people to become agitated and the effectiveness of staff responses. The MAR charts for one person showed they had been given a sedative on seven occasions during a two week period. Behaviour charts had not been completed for any of these occasions. When we looked at this person's care records, they provided no indication that the person had been anxious or agitated on those days, or that staff had tried other strategies to support them. We brought this to the attention of the registered manager who took disciplinary action against the staff member concerned. When we spoke with this staff member, they told us "I always gave it to [the person] when [they were] violent or when [they] couldn't sleep due to pain." Another staff member said, "If [the person] became agitated and angry I would give [them a sedative] and say 'There you go, that'll help your pain'. You knew then you weren't going to get hit and [they] wouldn't get out of hand." This showed they had not followed people's care plans or responded appropriately to people's needs. However, a third member of staff said, "I have never had to give [the person a sedative]. If you spend five minutes with [them] and talk to [them] with respect, [they] will respect you back and be fine." This showed they understood how to meet the person's needs.

For another person, whose assessment showed they might benefit from light and music therapy, there was no record of it being used, although a family member told us they had seen staff using it. However, they said, "The music [staff played] wasn't always appropriate, it used to be pop music, but now it's more age appropriate, from [the person's] era."

One person had recently returned from hospital where they had been treated for a broken hip following a fall. Their care plan stated: "need to do exercise to get her moving again", but did not explain how staff should do this in terms or what exercise might be appropriate. The main objective of staff appeared to be to stop the person from standing in case they fell. A member of care staff repeatedly told the person not to get up, saying, "No, no, no, you cannot do that; if you stand you will fall and you'll be in hospital again". We observed no attempts by staff to support the person to exercise in a safe way that would promote their recovery or to identify why the person wanted to stand repeatedly.

The epilepsy care plan to support a person who experienced seizures was not personalised to their individual needs. Guidance to staff on action to take when the person had a seizure contained generic advice and was not clear. It stated staff should "Assess and don't panic", but did not say what the assessment should include. It instructed to staff to "place a cushion under the person's

Requires improvement

Is the service responsive?

head", which was contrary to good practice guidance and could cause harm. It stated that the person could "fall to the ground", but did not take account of the fact that the person was unable to weight bear and spent their day in bed or in a specially adapted wheelchair.

The continued failure to support people effectively, consistently and in a personalised way, was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we identified that activity provision was not tailored to meet the individual needs and interests of people. At this inspection, we found improvements had been made to the way people's background, interests and hobbies were recorded in their care plans. This provided information to enable staff to plan suitable activities. However, activities were limited to three days each week when the activity coordinator was working, so did not meet the needs of all the people on a regular basis.

A family member told us people had watched Wimbledon while drinking cocktails. Another family member told us the provider had run a sports day earlier this year. They said, "We had a good afternoon in the garden. There was tea and cakes. All the relatives played rounders, as did some of the staff". The activity coordinator kept records of activities undertaken, which showed they spent time on a one-to-one basis with people who chose not to engage in group activities. They had a detailed knowledge of people's interests and clearly enjoyed talking to people about them.

Activity provision was not always delivered in a way that was appropriate for people with cognitive impairment. We observed two activities on the first day of our inspection. The first was a game of 'hangman' which involved people guessing letters that made up a word. Four people took part, but became confused with letters in the word they were creating and letters that had been discarded. The same four people took part in a game of bingo in the afternoon, together with two other people who were given bingo cards but were asleep. Some people had their backs to the caller and did not always understand the number called. The caller did not check that people had understood the numbers and people sometimes missed them. No activities took place on the second day of our inspection, other than a visit by the hairdresser.

All but one person were satisfied with the care they received. One person said, "I get all the help I need."

Another person told us they were happy at the home as "there is always something to laugh about". A family member told us "We're very satisfied with how they look after him. [He] has absolutely thrived since being there. He gets all his tablets when he should and is offered pain relief when needed." Another family member said of the staff, "I cannot fault them; they have done so much for [my relative]. She's putting on weight, her nails are cut. They've brought a lot of her character out."

The provider had undertaken a survey of relative's and resident's opinions in April 2015. Responses were largely positive. Issues that people rated as poor were the comfort of the beds and the lounge; the lack of choice about when to get up in the morning and the food. However, an action plan had not been developed to address these issues and there was no evidence to show the survey had been used to make improvements.

Since the last inspection, we found aspects of care planning had improved. Care plans were more detailed and provided sufficient information about how people's continence should be managed. Pain assessments had been introduced to help staff identify when people needed pain relief and MAR charts showed people received these when needed. Some staff were sometimes responsive to people's needs. For example, when a person started to choke on their food at lunchtime, an experienced member of staff took appropriate action to support the person effectively.

Care plans were developed using information from a range of sources, including the person, their family and professionals. The provider also used 'encounter sheets' from the person's GP which contained full details of their medical history. Reviews of care were then conducted regularly. People and their relatives were consulted as part of the review process and records of the consultations and their views were recorded. One family member told us "We sat down with [the deputy head of care] and talked things through. We got an appointment which was good, so I was able to ask [another family member] down for it. We went through the whole care plan. They listened and took notice of my views".

The provider had a complaints policy in place and we viewed examples of complaints that had been responded to promptly and in accordance with the policy. People and their relatives knew how to complain. A person who made a complaint at the time of our inspection told us they were

Requires improvement

Is the service responsive?

satisfied with the way it was subsequently resolved. A family member told us “There is a complaints form in the foyer if you need to make a complaint; and they also send us questionnaire forms twice a year”.

Inadequate

Is the service well-led?

Our findings

At our last inspection, on 28 November and 1 December 2014, we identified that staff were focused on tasks rather than the individual needs of people. Systems to monitor the quality of some aspects of the service were not effective.

In the report and warning notices we sent to the provider following the last inspection, we highlighted staff shortages; the lack of staff training to support people with behaviours that challenged staff; the lack of guidance on administering sedatives to people; and the failure of staff to follow the Mental Capacity Act. The provider's action plan outlined how they would achieve compliance with the regulations. At this inspection we found these areas had not been addressed fully and this had led to repeated non-compliance with regulations. This showed that the systems in place to act on our feedback were not effective.

In addition, we identified fresh concerns relating to people's skin care, epilepsy management, supporting people with behaviours that challenged staff and supporting a person with their mobility following a fall.

The provider conducted a range of audits. These included audits of medicines, infection control, the environment and care plans. The medicines audit comprised daily, weekly and monthly checks and had been effective in ensuring medicines were administered safely. However, the infection control audit conducted a month before our inspection had not picked up the lack of personal protective equipment in key places around the home; the cleanliness concerns in the laundry and the medicines room; the risks posed by sharing hoist slings; or that cleaning check sheets were not always completed. It had therefore not been effective.

Care plan reviews were conducted monthly, but had not identified concerns relating to people's skin care; the anomalies with a person's epilepsy care plan; the lack of information about how to support a person following a fall; the inconsistent response by staff when people became anxious and the failure of staff to complete behaviour charts consistently; the lack of best interest decisions or consultation with family members when people lacked the capacity to make decisions; or that food and fluid charts were not accurate. The system used to review care plans had, therefore, not been effective in ensuring compliance with the regulations.

The continued failure to operate effective systems and processes to ensure compliance with regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found staff were reactive rather than proactive in their response to people's needs and were not well organised. One person said they were not happy at the home "because it is not well run". They also told us "The staff are very, very task orientated. They need to be more organised." Our own observations confirmed this, particularly in the run up to lunchtime, during lunch and whilst the medicines round was in progress. We noted the registered manager spent most of their time on administrative work in an upstairs office away from communal areas where people spent most of their time. The deputy head of care also spent a lot of time in this office during our inspection, so neither were available to support and organise inexperienced staff. However, staff told us this was not usually the case and said the deputy head of care spent a lot of time "on the floor" with staff. A family member said of the staff, "They seem to be very organised when we go."

The culture of the service was not always supportive of staff. Whilst some staff told us management were "supportive" and "approachable", other staff disagreed strongly. One staff member said, "The relationship between staff and the management team has broken down. There's a rift between them. We need to cover a lot of hours and people can't get time off." Another staff member told us "I am too scared to say anything for fear of repercussions. You have to be strong to challenge [the management]. They don't care about the staff." Two members of staff described a member of the management team as a "bully". Comments included: "[The person] is a bully and has to have an audience; and "[The person] is a big bully and picks on people". However, another member of staff said, "As long as you're doing the job [the person] is OK; but I have noticed with other staff [they] can be quite stern, but usually it's deserved. For example, questioning why certain jobs haven't been done. A few staff don't work to the right standards."

Inadequate

Is the service well-led?

Staff meetings were held regularly and all staff were expected to attend. Most staff made negative comments about these meetings and described a blame culture. They told us the meetings were mandatory but they were not paid to attend them. There was an incentive to attend as this was when they picked up their wages. Comments included: "The main aim is to tell us how rubbish we are. It may be justified for some staff, but [management] tell you that every aspect of what you do is rubbish"; "You are embarrassed in front of everyone else. I was singled out and named as the person who had done [something wrong]"; and "They're not pleasant. You are always being told off for something, you never ever get praise". However, one member of staff told us "There are aspects of being told what is required, but sometimes it's justified."

Working relationships between staff at the home and the community healthcare team had broken down and each was highly critical of the other. This was to the detriment of people living at the home. For example, healthcare professionals had suggested that one person needed to have their continence assessed and referred the person to the continence service. Staff initially resisted offers by a continence healthcare professional to complete an assessment, which caused a delay in the person receiving the continence products they needed. Meetings had been held between the provider and the community nursing team manager, but these had failed to resolve their differences. A senior member of the local authority commissioning team told us "It is a significant feature of relationships between the home and outside agencies needing to work with them, that they seem totally resistant to any criticism, even when of a constructive nature. This could potentially impact on the quality of the care given to the residents".

There was high turnover of care staff. Some staff had chosen to leave the home and the provider had dismissed three members of care staff from the service, since January 2015, for misconduct. The misconduct related to staff failing to use safe moving and handling techniques, failing to follow infection control procedures, abusing people and treating people roughly. A family member said, "It's a pity about the staff turnover." The deputy head of care and three care staff had worked at the home for more than two years. The remaining nine care staff had worked at the home for less than six months, including three who had been recruited in the previous two weeks. The provider said staff turnover was "a problem" which caused additional cost and used a lot of management time. As a consequence, people did not receive care from a consistent staff team who knew and understood their needs well.

Family members and all but one person told us they felt the home was run well. Visitors told us they were always welcomed, and described the home as "homely". A family member said of the management, "They are so approachable here and always ask if everything is OK." Another family member told us the deputy head of care was "a good team leader." However, a member of care staff told us they would not place one of their loved ones at Stonehaven. They said, "I do my job as if it was my mother I was looking after. When I'm here I work hard to do things properly; but other staff do it as a job and are maybe not as caring." Another staff member told us "I would recommend it with the staff we have, [now that some have left], but not before".

A clear management structure was in place consisting of an experienced registered manager and 'deputy head of care'. A senior member of care staff was nominated to be in charge of each shift and to take responsibility for ensuring care staff provided the necessary care. The provider notified CQC of all significant events and the ratings from their previous inspection were prominently displayed in the reception area.

The service had recently employed a 'compliance officer' who was introducing a new quality assurance system to help the service meet the requirements of the regulations. This would provide up to date guidance on current regulations and best practice.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate and did not always meet their needs. Regulation 9(1)(a) & (b).

The enforcement action we took:
We imposed a condition on the provider's registration to prevent them from admitting new service users without the prior written person of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not follow the Mental Capacity Act, 2005 where people lacked the capacity to make decisions. Regulation 11(1), (2) & (3).

The enforcement action we took:
We imposed a condition on the provider's registration to prevent them from admitting new service users without the prior written person of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as infection control arrangements were not adequate. Regulation 12(1) & (2)(h).

The enforcement action we took:
We imposed a condition on the provider's registration to prevent them from admitting new service users without the prior written person of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Systems and processes were not established and operated effectively to ensure compliance with the regulations. Regulation 17(1) & (2).

The enforcement action we took:
We imposed a condition on the provider's registration to prevent them from admitting new service users without the prior written person of CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Insufficient numbers of suitably qualified, skilled and experienced persons were deployed to meet people's needs. Staff did not receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties effectively. Regulation 18(1) & (2)(a).

The enforcement action we took:
We imposed a condition on the provider's registration to prevent them from admitting new service users without the prior written person of CQC.