Stonecross Care Home (Kendal) Ltd

Stonecross Care Centre

Inspection report

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Kendal
Cumbria
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18 July 2023
20 July 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stonecross Care Centre is a residential care home registered to accommodate up to 32 people in need of personal care. Accommodation is provided over 3 floors with some rooms having en-suite facilities. On the days of the inspection there were 20 people living at the home.

People's experience of using this service and what we found
Aspects of staff recruitment were not completely effective at ensuring staff members were always suitable to work with vulnerable people. Some essential safety checks had not been made. This was a breach of regulation at the last inspection and we found this was a continuing breach at this inspection. There was no documented provider oversight of these processes.

Care, support and environmental risks to people were not always appropriately identified, assessed or managed. At the last inspection, there were significant fire safety issues. The local fire service intervened. Although we noted some improvements in that position and other environmental concerns, issues were still outstanding and the provider had no active plan to resolve matters.

People received their medicines as prescribed by health care professionals. Some medicinal cream use required attention but these were addressed at inspection.

Infection, Prevention and Control (IPC) processes were appropriate and we were assured about the service's ability to mitigate the transmission of infections. The service had recently been visited by a local authority specialist and we noted most recommendations had been acted upon.

Staff were competent with safeguarding processes and knew how to protect people from abuse. Relatives said their loved ones felt safe in the home and were trusting of staff and management. We observed good practices and interactions between staff and people during the inspection. The service's safeguarding processes were robust.

Staff supported people to have access to healthcare professionals and specialist support and the service worked with external specialists. Professional's views on the service were mixed but those we spoke with at inspection said that the service was improving.

People were confident in the management team at the home and praised how approachable they were.

The service made appropriate notifications to CQC and other authorities of safety incidents to ensure these incidents received appropriate oversight.

The manager and registered provider was responsive to concerns noted during the inspection and started to take action to make improvements and promote safety within the home.

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 30 June 2022) and there were breaches of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

At this inspection, we found there were only limited improvements and the provider continued to be in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service. As a result, we carried out a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service remains 'requires improvement' based on the findings of this inspection.

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.

We have found evidence that the provider needs to make improvements. Please see the 'safe' and well-led' sections of this full report.

Enforcement
We have identified breaches in relation to risks to people, unsafe recruitment processes and the governance of the service at this inspection. In this connection, the provider was issued with 2 Warning Notices. This means we may take further action if the provider does not comply with the Notice and the breaches are continuing.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority and other partner agencies to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect and will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Stonecross Care Centre

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 Care Act 2014.

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 conducted by 2 inspectors.

Service and service type
Stonecross Care Centre 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager in post who was in the process of applying for registration.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 July 2023 and ended 20 July 2023.

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, the fire service, commissioners and professionals who work with the service. We also looked at information we had received and held on our system about the service, this included notifications sent to us by the provider and information passed to us by members of the public.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service. We spoke with 5 relatives about their experience. We spoke with members of staff including the manager and deputy manager, 2 provider representatives, a cook and 4 care workers. We also obtained feedback from 2 health care professionals who regularly visit the service.

We looked at a variety of records to gather information and assess the level of care and support provided to people. We reviewed 4 care records. We looked at staff rotas, risk assessments, multiple medicine records and 4 recruitment files. We also considered a variety of records relating to the management and governance of the service, including policies and procedures.

We looked around the home in both communal and private areas to establish if it met the needs of people who lived there and if it was safe.

Requires Improvement

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. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to identify and act on risks to people in the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

● Some risks to people were not handled appropriately. For example, there was a lack of oversight of weight monitoring, accidents and incidents, falls risks and poor recording of people's food and fluid intake. There were poor records of action being taken to mitigate risks.
● Since the last inspection, a programme of fire safety improvements had been implemented. This work had been completed following action by Cumbria Fire and Rescue Service. However, that had led to instructions to a specialist fire engineer who had visited the service and provided a report that was received by the service 7 weeks before this CQC inspection. The report made a number of recommendations, some of which required action within 1 month. None of this had been actioned and the provider did not have an action plan in place. Further comment on this point can be seen in the 'well-led' section of this report.
● Some environmental checks were not being completed. For example, although there were restrictors in place to ensure the water people used was safe and at an appropriate temperature, these were not being checked to ensure control systems were effective.

We found no evidence that people had been harmed. However, these series of risks were not identified and acted upon and were a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff promptly acted on any concerns they came across such as the development of pressure sores and shared them with relevant healthcare professionals. We noted external professional's views were considered and acted upon.
● Other environmental concerns such as the potential for people accessing items that could be harmful to them and accessibility of the home's kitchen had been resolved since the last inspection.
● Equipment used to support people had been serviced and inspected consistent with manufacture's guidelines. These included moving and handling equipment. The main lift in the home was out of action at the time of inspection. We were assured action had been taken to secure replacement parts and the employment of specialist engineers.

● During the inspection, the provider representatives and manager told us a review of outstanding issues would be actioned and CQC kept informed of developments.

Staffing and recruitment

At our last inspection the provider had failed to robustly deal with the recruitment of staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19.

● The provider did not always follow safe recruitment procedures. They were not properly assessing staff members' fitness to work with vulnerable people. Checks with previous employers in health and social care and other important checks had not been completed in most of the recruitment files we considered.
● Essential checks such as those into identity, right to work and criminal records had been made.

We found no evidence that people had been harmed. However, these recruitment omissions were a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff employed. Rotas and our observations at inspection supported this position.
● During the inspection, the provider representatives and manager told us an immediate safety review of all staff employed would be actioned and CQC kept informed of developments.

Using medicines safely
● People received their medicines as prescribed by healthcare professionals. However, records around the application of essential creams were inconsistent with good practice.
● When people were unable to take their medicine, pharmacists or GPs had been consulted and appropriate action taken.
● Staff had been trained on the safe administration of medicines. A senior member of the care staff told us they took the administration of medicines seriously and said it was an important part of their care and support of people. They said their competence in this area had been checked in the past. Records supported this position.

Learning lessons when things go wrong
● Areas of concern were not always elevated to the registered provider. This hampered the opportunity to learn lessons from incidents.
● The manager was developing a system to review accidents and incidents so lessons could be learned. We noted this included looking at all falls for trends and themes and this included a degree of provider led oversight.

Preventing and controlling infection
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises. The home was clean, but did note areas and that required refurbishment and maintenance.

● We were assured personal protective equipment was used safely to minimise the risk and spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider was facilitating visits for people living in the home and there were no restrictions. This was in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at the home. The manager and registered provider had a system for responding to and reporting abuse. One person told us they felt the home was a safe place for people to live and they had no concerns. One relative said, "My relative is very safe, they do everything for them."
● Staff told us they had received safeguarding training and were aware of the importance of reporting abuse. They said they were confident about intervening when abuse may be suspected and were assured the manager would act appropriately in these circumstances.

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. Any conditions related to DoLS authorisations were being met.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence 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 inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to effectively oversee the service to ensure compliance with safety requirements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● The registered provider did not always understand risk and regulatory requirements. Directors from the provider said since the last inspection in 2022 they had an increased understanding of their role and quality assurance. However, they were unable to demonstrate how quality assurance and oversight of the service was performed and embedded. For example, at inspection, they accepted there was no documented provider oversight available for the inspection team to consider.
● Prior to inspection, the provider representatives said they were unaware of most issues seen in the 'safe' section of this report. This lack of oversight meant there was no active action plan to address failing and improve the service.
● Some staff members informed us they did not have confidence concerns they escalated to the provider would be addressed. One staff member gave us an example of a safety concern that had been escalated but not addressed by the provider.

This series of failures to oversee the service effectively were a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Since the last inspection, we noted the provider had implemented a substantial fire and home environment improvement programme. The local fire service was satisfied their requirements from their inspection in May 2022 had been met. They were aware of the additional fire safety findings from this 2023 inspection and were monitoring the provider's progression of these issues.
● A new manager had recently been appointed who was applying for registration with CQC. We received some assurances auditing systems within the service were in the process of being reviewed. They said, "I am committed to improving the service and am working hard to address issues." A healthcare professional said, "We have seen some improvement since the last CQC inspection but further work is required around staff

members' knowledge of patients."

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

● The manager was clear about their role and responsibilities, including under the duty of candour. They had notified us of significant events, as required, and had been open and honest with relevant people when incidents occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● During the inspection visit, we saw positive and caring interactions between staff and people who lived at the home. People told us they were happy with the care and confirmed they received person-centred care. Relatives confirmed they were happy with the care provided to their family members. One said, "My relative is well cared for. If there is anything different to the way they usually are, [staff] get them checked over."

● The manager was open and honest about the failures seen at inspection. They said, together with the provider, they were already undertaking a number of changes to improve the service and were committed to working in partnership with other agencies to make the required improvements to ensure the home was safe.

● We saw evidence of partnership working with health and social care professionals to meet people's needs. During the inspection we were approached by a health care professional who said they had been completely supported during their visit, had seen improvements in the management of the service since the last inspection and had no concerns around the care of residents.

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

● People were involved in how the service was managed. Relatives told us the service engaged in regular communication with the home. We saw evidence of positive engagement between the management team, relatives and people who lived at the home. One relative said, "We have good communication with the staff. We review [relative] care plan once a year. We are totally confident they are getting what they need."

● Staff we spoke with told us they felt listened to and were supported by the management team within the home. One said, "I don't know about the owners but the new manager is very professional and has time for everyone. Under their leadership, we hope this home will succeed."