Stepping Stones Resettlement Unit Limited

Stepping Stones

Inspection report

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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
Stepping Stones is a residential care home providing personal care to 32 people at the time of the inspection. There are eight different houses set in in 4.5 acres that can support up to 33 people living with a learning disability or autistic spectrum disorder.

People's experience of using this service and what we found
The management of people's risk had been assessed and were known by staff, however identified strategies used to support people to mitigate their risks such as risk of choking had not been assessed by specialist professionals.

The provider's own quality assurance systems had not been effective in identifying gaps in fire drills, water checks, recruitment records, people's risk management plans and notifications. The provider could not always be assured that infection control practices were being maintained as their auditing systems did not reflect recognised COVID-19 control measures.

The service supported people to review their medicines prescriptions and to help reduce the risk of overuse of unnecessary medicines although we found some improvements to medicine management were needed.

The provider continued to actively recruit staff to vacancies. We made a recommendation to support robust recording of pre-employment checks undertaken.

Systems were in place to protect people from harm and abuse. Progress was being made in ensuring all staff had the skills to carry out their role. Staff told us they felt supported but reported that communication needed to improve. This was also reflected in some health care professional's feedback about the service. We have made a recommendation to support the improvement of external incident reporting.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Based on our review of key questions of safe and well-led, the service was not able to fully demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support
People were supported by staff who understood their care and support needs, and what was important to them.

Although staff knew people well, people were not continually supported to achieve their aspirations and goals. People were not always supported to have maximum choice and control over their lives. There was slow progress in ensuring people were being supported to follow their interests and goals now that the COVID-19 restrictions have been eased.

People were supported to access specialist health care services and maintain contact with their families.

Right care
People's risks were identified and managed well by staff. People's care records reflected their emotional and health needs but lacked details about their social and leisure/occupational aspirations and how they wanted to be supported to achieve this. Further development was needed to demonstrate that people's lives were enriched by a service that focused on their wishes, needs and rights.

Health care professionals praised the service and how they had supported people through the pandemic.

Right culture
Staff had positive relationships with people and their relatives. There was visible interim leadership and management of the service in the absence of a registered manager.

The model of care being provided at Stepping Stones did not fully maximise people's choice, control and independence. The provider had identified areas that required improvement and was working on their recovery plan to address the impact of the COVID-19 restrictions. However further time was needed to enable the provider and management team to demonstrate how the improvements being made would enhance people's quality of life and well-being for all people living at Stepping Stones such as empowering people to live a life of their choice.

The provider recognised that their values and the principles of Right support, right care, right culture guidance needed to be fully understood and embedded into staff practices to ensure people were explicitly supported to live a fulfilled life.

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

Rating at last inspection
The last rating for this service was Good.

Why we inspected
We received concerns in relation to staffing levels and the management of people's medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only and to assess that the service is applying the principles of Right support, right care, right culture guidance.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at 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 improvement. Please see the safe and Well Led sections of this full report.

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

Enforcement and Recommendations
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 to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, people's safety and the provider's monitoring systems at this inspection.

We made two recommendations regarding pre-employment check recording and incident notification to support improvement.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published and request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Stepping Stones

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
Two inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. 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
Stepping Stones 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. [Care home name] is a care home [with/without] nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a registered manager. There was no registered manager in post at the time of the inspection, however the provider had ensured interim management arrangements were in place while they appointed a new 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the intelligence that we held about the service and feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and five relatives about their experience of the care provided.

We spoke with 10 members of staff including the nominated individual, deputy manager, clinical lead, head of maintenance and seven care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and a number of medicine records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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; Learning lessons when things go wrong

- The provider had systems in place to identify and mitigate people's risks, however, these had not always been robustly followed.
- Staff were aware of those people who were at risk of choking and had taken some measures to reduce the risks. However, the service had not sought specialist advice when people had been identified as risk of choking to ensure the arrangements in place were sufficient to keep people safe when eating and drinking.
- Risk management plans for people living with diabetes and epilepsy did not comprehensively provide information about the actions staff should take if people were to become unwell. Not all staff were able to describe the actions they should take if they were required to support a person experiencing a seizure. This put people at risk of not receiving the appropriate care.
- Positive behaviour plans were in place which guided staff on how to support people if they became distressed or anxious. All incidents where people had been distressed were recorded and reviewed by the managers and the provider's Behavioural Support Lead to ensure staff interventions remained appropriate. However, it was not always evident that some of these recommendations or referrals to specialist services had triggered a review of people's positive behaviour support plan to ensure these remained up to date and effective in keeping people safe. This meant staff did not always have access to current information on how to support people.
- Plans were in place to keep people as well and those living with them safe if they were to become distressed. However, on the day of our inspection the escalation plan in place required staff to wait for support from another household which placed people at risk of not getting immediate support when distressed.
- People were not always protected from environmental risks such as fire risks and those relating to water safety and infection control. Planned fire evacuation drills had not been undertaken to assess the effectiveness of people and the provider's emergency evacuation plans. A schedule of water checks had not been maintained to monitor the likelihood of legionella bacteria developing.

Systems were either not in place or robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Procedures were in place to ensure pre-employment checks were completed prior to staff commencing employment. However, the provider did not have sufficient oversight of the recruitment process and had not identified that some records were not complete.

We recommend that the provider review their recording of completed pre-employment checks.

● We received several comments from staff about staff shortages in the service. They explained that on occasions staffing had not been at the required level which meant they were unable to provide care which enabled people to live a life of their choice.
● The provider recognised they needed to ensure a balanced team of staff were working to ensure people's needs were met. We saw they were taking action to recruit additional staff and deploy staff more effectively. Team leaders were on hand to provide additional support where needed and they planned to review and prioritise how staff were deployed to minimise the risk to people.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.

People were supported to see their families in accordance with their preferences and in line with government guidance.

Using medicines safely
● The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.
● People took their medicines in an area where they felt comfortable and were supported by staff.
● Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.
● Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing. Where appropriate, this involved external teams such as the Community Learning Disability Team.
● Medicines were stored safely.
● Managers reviewed medicines related errors, reflection was encouraged, and lessons learnt were shared. Medicines audits were in place and actions were implemented.
● We found that staff did not follow specialist advice when administering one person's medicines. However, this was rectified during the inspection.
● Staff were trained in the safe administration of medicines but were not always assessed regularly to ensure they were competent. However, plans were in place to address this.
● People received their medicines as prescribed although medicines administration records were not always completed according to the provider's medicines policy.

Systems and processes to safeguard people from the risk of abuse
● Some people told us they were not fully assured about their safety at Stepping Stones but were not able to

expand on their feelings. We raised this with the nominated individual. They described to us the new monthly meetings people were having with their named care worker to raise any concerns or safety issues. These discussions were documented and were currently being reviewed by the nominated individual so that action could be taken if needed.

● The provider had systems in place to protect people from the risk of abuse, however, some staff's understanding of reporting was limited. Staff told us they would tell the manager if they were worried people were being abused. However, they did not know who else they could report abuse to. The provider planned to review their safeguarding reporting process with staff.

● CQC was not notified of all safety incidents between service users to ensure all relevant agencies could monitor people's safety. We found two incidents which had not been notified to CQC.

We recommend that the provider reviews their system for identifying when external incident reporting is required.

● Relatives confirmed that they felt people were safe living at Stepping Stones. They would recognise changes in people's behaviours and emotions if people were unhappy and felt confident these would be addressed.

Requires Improvement

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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

- The deputy manager and senior staff (supported by the nominated individual) had managed the service in the absence of a registered manager being in post. A new manager had been appointed. They were still to submit their registration application to ensure the provider met their registration requirements.
- The provider had a system of audits to monitor the quality of the service. However, these had not identified the issues we found during the inspection such as fire drills, water checks, recruitment records, people's risk management plans and notifications.
- The provider's infection control audits had been completed but had not been adjusted to reflect the additional infection control practices required to reduce the risk of the transmission of the COVID-19 virus. It therefore did not identify the concerns we found in relation to cleaning schedules and effective use of PPE. This meant the provider could not be assured that the control measures which had been put in place to help prevent the spread of coronavirus were being completed.
- Systems were in place to monitor staff training and development; however prompt action had not been taken to ensure staff received medicines competency checks in accordance with national best practice guidelines.
- The provider's systems to assess and manage the staffing levels across the service was unable to demonstrate how they planned and ensured that people received their commissioned funded one to one hours and how these additional hours were used to achieve positive outcomes for people such as achieving personal goals, visiting their family home or attending community-based activities.
- Quality monitoring of people's care and medicines management practices had not always identified shortfalls we found in relation to when health professional referrals were needed or when recommendations had not been implemented and reflected in people's care plans.

Systems were either not in place or robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was making progress to re-introduce a more effective key worker system and for staff to attend classroom-based training for key subjects with the aim to improve the quality of care being provided. They recognised that some staff needed to improve their confidence and skills in delivering good quality of care and supporting people to engage in the wider community and activities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We found staff positively engaging with people throughout the inspection. We were provided with several examples of how people had been supported to achieve positive outcomes. However, we found at times people did not always receive the support they needed to have choice, control and independence. For example, there was not a consistent approach in enabling people to reach their potential such as developing further skills in the kitchen.

● People's care records did not reflect their social and leisure/occupational aspirations and how they wanted to be supported to achieve this.

● People or their representatives were not always involved in making decisions about people's medicines. Care plans for medicines did not always show if a person could be involved in administering their own medicines or supported to do so in time.

● It was not evident how the provider had reviewed and developed a model of care which had addressed the possible impact of people living in a community and rural setting.

● The communal areas of some people's homes looked tired in parts and it was not clear how people were involved in decisions about their home and their sensory needs. We discussed this with the provider, who shared examples of pending refurbishment projects and the building of sensory rooms and outdoor equipment such as swings in the gardens.

Systems to ensure people received care which was personalised and focused on their needs, choices and aspirations were not effective. This was a breach of regulation 9 (Person- Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed our observations with the managers and nominated individual who showed how they were working towards an action plan to address our concerns and reintroduce activities. However, further work was needed to ensure that people's care was explicitly focused on their needs and choices and how the provider would evidence this.

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

● The provider had systems in place to engage people, their relatives, staff and professionals but these were not always meeting people's needs.

● Staff told us they felt supported by the managers and senior staff although some staff felt communication needed to improve. One staff member said, "We don't get to hear about all the changes especially if we are off work for a while."

● Relatives told us communication from the service was variable and depended on the skills and confidence of people's key worker and the management team on duty. The provider said that they recognised that the key worker system was an area that needed further development. Relatives told us that staff involved them in decisions about people's care. One relative said, "I am a regular visitor and I am involved with my son's care planning."

● A health care professional stated they felt good communication between the service and community professionals needed to be re-established following the pandemic.

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, Continuous learning and improving care

● The provider understood their responsibilities under the duty of candour.

● Relatives told us they were usually informed if things had gone wrong. Relatives told us that if they made complaints these were responded to appropriately.

Working in partnership with others

● Records showed that staff worked in partnership with health care services and supported people to attend routine health care and health screening appointments.

● Health care professionals praised the professionalism of the managers throughout the COVID -19 pandemic and said staff had worked flexibly during the restrictions to meet people needs. One health care professional said, "I see that the team generally know the service users they support and are eager to work in partnership with us and are respectful to outside organisations."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems to ensure people received care which was personalised and focused on their needs, choices and aspirations were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been effectively operated to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.