

Aura Care Living LTD

Stratton Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Stratton Court is a residential care home providing accommodation to persons who require nursing or personal care, for up to 84 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 56 people using the service. People are accommodated in one adapted building.

People's experience of using this service and what we found

The manager and provider had implemented new monitoring systems to continue to improve the quality of the service people received. The management team were implementing new governance systems based on their own analysis and professional feedback. While the new governance arrangements had brought about improvements, more time was needed to allow these systems to bring about and sustain good outcomes for all people.

People's care records were not always current and reflective of their needs. The management team was aware of this shortfall and was taking action to improve people's care records.

Whilst improvements had been made to promote people's person centred care throughout the home, people living with dementia might not have always received care which promoted their wellbeing and was personalised to their needs. People and their relatives had not always been involved in planning their or their loved one's care. Plans were in place to continue to improve care that met people's individual needs and preferences.

People's risks had been assessed and clear guidance was available for care and nursing staff to follow. Where people had specific healthcare needs, these were clearly documented. There were systems in place to monitor people's needs and ensure people received appropriate care following incidents and accidents.

The management team was working with an independent professional to focus on staff training and competency. They were focused on improving staff communication and knowledge with the aim of improving the quality of care people received.

Improvements had been made in relation to people's prescribed medicines. Staff had received support and training to administer people's medicines safely. The management team had implemented new systems and had taken action to ensure people received their medicines as prescribed.

Risks relating to the environment were now assessed. The management team and provider had clear systems in place to ensure people were protected from the risks associated with their environment.

Staff supported people in the least restrictive way possible and in their best interests. Where people were living under Deprivation of Liberty Safeguards; staff understood the support they required.

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 were assured the service were working in accordance with government guidance.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 10 August 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made, however the provider was still in breach of two regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 28 and 29 June 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, person centred care and good governance.

We undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulations 12 and 17, and a requirement notice in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also received information of concern in relation to people's personal care since our last inspection.

This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

For the 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. This is based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stratton Court 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 will take further action if needed.

We have identified a breach in relation to person centred care and care records in the Responsive key question, at this inspection.

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

Follow up

We will 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?

Good ●

The service was safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Details are in our well-led findings below.

Stratton Court

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Stratton Court 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. Stratton Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

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 wasn't a registered manager in post. There was a manager who was in the process of registering with CQC. After the inspection the manager was registered with CQC.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We used the information the provider sent us in their latest provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information and feedback we had received from local authority commissioners in relation to Stratton Court. We used all this information to plan our inspection.

We received feedback from a range of healthcare professionals and local authority commissioners prior to our inspection.

During the inspection

We spoke with 19 staff including the manager, the compliance and governance director, deputy manager, 2 nurses, 2 unit leads, 2 senior care staff, 1 housekeeper, 1 maintenance worker, 2 lifestyle co-ordinators and 6 care staff. We also spoke with 2 representatives of the provider. We spoke with 11 people living at Stratton Court and with 8 people's relatives. We also spoke with 2 healthcare professional who visited and supported the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including governance systems, policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has changed to good. This meant people were safe and protected from avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. People had not always received their medicines as prescribed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

Assessing risk, safety monitoring and management

- People's risks were assessed and known by care and nursing staff. One person was assessed as being at high risk of falls. Staff were aware of the risk and took effective action to ensure the person remained safe.
- One person was living with diabetes. The person had a clear care plan which staff followed. Nursing staff kept a record of the person's blood sugar levels. Staff sought the advice of healthcare professionals and worked with the person to manage any health-related risks.
- One person had made a clear decision around their dietary needs' contrary to professional advice. Staff understood and respected the person's choice to eat and drink 'at risk'. The person was involved in planning their care which provided clear details on how they should be supported. Staff told us how they supported the person to respect their decision and promote their wellbeing.
- Since the last inspection, the management team had taken effective action to ensure people were protected from the risk of their environment. There were clear systems in place to monitor cleanliness, fire safety and environmental risks, such as legionella.

Learning lessons when things go wrong

- Since our last inspection the management team and provider had implemented systems to ensure people remained safe following incidents and accidents. Where one person had been assessed at being at risk of falls, they had been prescribed blood thinning medicines. Care and nursing staff worked alongside professionals to ensure the person received the correct medicine to keep them safe in the event of a fall.
- The manager and provider had taken effective action following concerns raised around cleanliness. This included implementing walkarounds, including bedroom and wardrobe checks to identify and infection control risks. The manager talked positively about learning from concerns, incidents and accidents to improve the quality of care people received.

Using medicines safely

- People's medicines were stored safely, and they had received their medicines as prescribed. The management team had also sought the service of a new pharmacy to improve the timely supply of medicines to Stratton Court.

- Systems had been implemented to reduce risks associated with people's medicines management. The management team and provider had supported staff with training and guidance. This enabled them to ensure staff had the right skills and competency to administer people's medicines safely.
- Some people were prescribed medicines that were to be administered 'as required' when they could be anxious or distressed or were in pain. Since our last inspection the management team had reviewed and updated people's 'as required' protocols. These contained clear guidance for staff to follow, including when to administer these medicines and how to review the effectiveness of their prescribed medicines.
- Nurses and managers completed daily, weekly and monthly medicine checks. These audits had supported improvements in how people's medicines were managed.

Staffing and recruitment

- Staff were recruited safely. All required checks were made before new staff began working at the home. Disclosure and Barring Service (DBS) checks were completed alongside seeking references from staff's previous employers. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Recruiting managers kept a record of when they had sought references and not received a response. This enabled them to ensure appropriate checks were carried out or seek additional references if required.
- Suitable staffing levels were in place to meet the needs of people using the service. The manager had increased staffing levels since our last inspection, this decision had been based on people's needs. The manager and provider had recruited new staff to Stratton Court and had reduced agency usage. People and relatives spoke positively about this change.
- People and their relatives told us there were enough staff to meet their loved ones needs. They spoke positively about staffing, including the reduction of agency. One relative told us, "There is less agency now. The staffing team is more consistent, we can see this is better for [relative], they are familiar with staff."
- Staff told us there were enough staff and they had the time they needed to provide people's care. Comments included; "Things have definitely improved. We could always do with more staff, however we do get everything done" and "Staffing has definitely improved. It was tough over the summer, however it's good now, we're positive."

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

Visiting in care homes

The provider was following current government guidance in relation to visiting at the time of the inspection. Relatives spoke positively about visiting Stratton Court.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt the home was safe. Comments included: "He is absolutely safe" and "I always feel she is safe and well cared for."

- The manager and management team were visible and regularly worked alongside staff which made it easier for any concerns to be identified or reported. The management team had started regular meetings to enable people to share any concerns.
- Staff had read the provider's whistleblowing policy and procedures and felt able to report any concerns about poor practice or inappropriate staff behaviour. One member of staff told us, "Any concerns I would go to the management. They're approachable."

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.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. This meant people's needs were not always met.

At our last inspection people had not always received care which was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the management team and provider had made improvements around people's person centred care, however was still in breach of Regulation 9.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The care plans for people living with dementia, did not always support person centred care as they were not always an accurate reflection of their individual needs and preferences. For example, for 4 people living with dementia there was limited information on the activities they enjoyed or how staff should promote their wellbeing. Staff were not always aware of people's interests, life histories and the things that were important to them. This could support conversation and development of individualised activities. One relative told us, "[relative] likes to read magazines, it's important for them. However, I don't believe staff know this."
- There was not always clear tailored engagement or activities for people living with dementia. Improvements had been made and people were supported to access communal areas. However, people did not always have sufficient individualised opportunities for social engagement or occupation as staff were not always aware of people's preferences or how best to engage them. One relative told us, "There are limited activities, feel there is a lack of mental stimulation for her and some activities on sheet don't happen." Another relative told us, "Activities aren't good. Weekends can be very quiet."
- We reviewed care records for people living with dementia and found, while records had improved in relation to how activities were to be recorded, there was not always a clear record of the activity related support people received. Some people went days without a documented activity or engagement from staff.
- Two people's care plans did not detail their full preferences and the support they received from staff. We observed staff assisting these people and reassuring them when they were anxious. The person's care plan did not reflect the support provided by staff including different techniques and options staff could take to reduce their anxiety.
- People and their relatives had not always been involved in planning their care. While the management team had taken action to start engaging with people's relatives and representatives, some relatives told us they had not been given the opportunity. One relative told us, "[Family member] sat down with the unit lead and went through things. Not a lot of input since then and no review." Another relative told us, "When she went there this was our biggest frustration. I asked to see [care plan] and they printed out 110 pages! There

is no summary of key issues like falls, what she eats etc. But I know [manager] is on this."

People's care had not always been planned and delivered in a way that was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The care plans for people living on the dementia unit and nursing unit were not always detail or reflective of their current needs. For example, staff discussed that one person liked the company of people of the opposite sex and enjoyed company with another resident. There was no care plan or guidance for staff to follow on how to support this person and protect them from any avoidable risks.
- One person's care and support had changed following an incident in the home. Whilst staff and management could discuss these changes, there was no record of this change in the person's care plan, including the support they currently received.

People's care plans were not always current and reflective of their needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team and provider were aware of these concerns and had plans in place to ensure everyone living at Stratton Court had access to activities and engagement which were tailored to their needs. Following our inspection, the manager and compliance and governance director told us the action they were taking to continue improvements in relation to activities and people's care records.
- The home had recently appointed a second lifestyle co-ordinator who was planning to focus on providing one to one care and assisting the current lifestyle co-ordinator. The management had identified the need for more support to resources to ensure everyone has access to effective engagement and simulation.
- The lifestyle co-ordinator organised entertainment and carried out activities for people at Stratton Court. They had plans to increase the involvement of people living with dementia and those who were cared for in bed, including using therapy pets. The lifestyle co-ordinator had a clear objective of promoting the engagement between Stratton Court and the local community. This included engagement with local schools, arranging regular baby and toddler sessions and church sessions within Stratton Court. The lifestyle co-ordinator had provided resources and support to care staff to help promote activities and engagement within Stratton Court. They told us, "things have improved, I do feel there is more going on, I have a lot of support."
- Where people were able to contribute to their care plans, staff had supported them to ensure their preferences were documented. For example, one person's care plan detailed their preferences and provided staff clear information on their life history and how they liked to be addressed. The unit lead told us they focused on ensuring there were detailed person-centred care plans in place for all people to inform staff to improve the quality of care people receive.
- Staff and people talked positively about the relationships they were building. One person spoke positively about the reduction of agency staff, meaning they were more familiar with the staff caring for them. They told us, "I am learning to count in the carers language, they like it."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were identified, assessed and recorded in care plans. They referred to how people communicated their needs and any support they required.

Improving care quality in response to complaints or concerns

- People and their relatives told us they knew how to make a complaint to the service. Comments included, "There was a bit of an issue with [a visiting professional], people have complained about them not spending long with them, and they are now changing who comes" and "I feel that if we have an issue, we have people to go to now and we know it is taken seriously".
- The management team kept a record of complaints and concerns they had received. The management team used complaints as a way to change and inform the service they provided. One complaint had been made around cleanliness in one person's room. The management team changed their audit process to focus on cleanliness in people's rooms and in wardrobes to ensure effective cleaning was being carried out.

End of life care and support

- People were cared for at the end of their life through the service working in partnership with health professionals. Staff spoke positively about end of life care and ensured people received the care and support that was important to them, including being visited by their loved ones. One person was being supported with end of life care. Nursing and care staff spoke compassionately about the support they were providing and how they were working with professionals to ensure people were comfortable and free from pain.
- Where able to do so, people had recorded their wishes for their end of life care, and these were known to the staff. One person had clearly documented their views on the end of their life and medical support they required. For people living with dementia there was not always a clear person-centred care plan of their preferences around their end of life care.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has 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.

At our last inspection systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not operated effectively. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management and provider had made improvements in relation to the quality and risk monitoring of the services. Some improvement was still required in regards to people's care records. We have reported a breach of Regulation 17 in regards to people's records in "Is the service responsive?" section of this report.

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

- Since our last inspection the provider had recruited a new manager and management team for Stratton Court. The manager had also recruited unit leads and clinical leads recently prior to our inspection. The clinical leads and unit leads were providing support to staff and were implementing new quality and risk systems to promote person centred care.
- New systems had been implemented to monitor the quality of the service people received at Stratton Court. We found improved governance arrangements in, for example, the monitoring of environmental risks and the management of medicines. However, there were some systems which were still being embedded to monitor whether people received individualised care, such as the newly introduced Resident of the day check and the accident and incident system. Whilst these improvements had been made, the management team and provider were aware that further improvements were required in relation to accident and incident recording, person centred care and care records for people living with dementia.
- Since our last inspection, the manager and compliance and governance director had identified improvements were required in relation to staff skills. They had sought the support of a training consultant and had identified clear training pathways (including dementia, moving and handling, learning disabilities and autism) for staff and the support required. The consultant told us, "I have put the training pathway into place. I was really surprised. There is involvement and willingness from everyone."
- We observed the manager and members of the management team led by example and were visible throughout the home. A staff member told us, "There is always someone around and the office door is always open."

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

- The management team had implemented some immediate changes around people's care which had led

to some positive changes for people living with dementia. This included supporting people who were mainly cared for in bed to access communal areas. The management team had identified for these people their individual skills had improved and for a number of people needed less support with their dietary needs. The management team had implemented an expectation for all staff to be available at lunch time to promote a positive and effective mealtime experience.

- Staff spoke positively about the improvements being made at Stratton Court and how this was impacting on them and the people they supported. Comments included: "Things have really improved since August. We've all been involved" and "I think we have a better culture here; it's having a positive impact for people. There is still more we need to do, however I feel confident we're going in the right direction."

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 and provider understood requirements in relation to duty of candour and had an open and honest approach.
- The provider displayed their Care Quality Commission (CQC) rating within the service and on their website.
- People knew who the manager and members of the management team were and how to complain. The manager and management team were developing their relationship with relatives so they also felt confident with raising issues and concerns with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The manager and management team had identified the need to improve communications with people, people's relatives and representatives. They had implemented relative meetings and increased engagement with relatives, including supporting relatives to become volunteers within Stratton Court. People and their relatives spoke positively about changes in the home. Comments included: "I have good confidence in the new leadership team" and "I wasn't sure [at first] but with the new managers I feel they are on a journey and getting there, they need time."
- The management team and lifestyle co-ordinator told us they intended to further improve engagement with the wider community, to promote intergenerational integration and engagement.
- The manager has requested to join a recognised local management support group for care home managers. The manager is aiming for this to promote their management relationships and help them inform ideas to improve the quality of care people received at Stratton Court.
- The service worked in partnership with health and social care professionals to ensure people received the best possible outcomes. Healthcare professionals spoke positively about improvements at Stratton Court, however expressed some concerns on whether these will be sustained. The service was open to working with professionals and had implemented guidance to staff to improve communication with professionals to ensure any concerns were addressed promptly.

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
Treatment of disease, disorder or injury	People did not always benefit from effective engagement and stimulation. People's care plans weren't always person centred. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's care assessments were not always current, contemporaneous or reflective of people's needs. Regulation 17.