

Stretton Care Limited

Stretton Nursing Home

Inspection report

Manor Fields
Burghill
Hereford
Herefordshire
HR4 7RR

Tel: 01432761066

Website: www.strettonnursinghome.co.uk

Date of inspection visit:

10 October 2019

11 October 2019

14 October 2019

Date of publication:

19 December 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Stretton Nursing Home accommodates up to 50 people within a large adapted building, and specialises in care for older people with physical disabilities and sensory impairments, who may be living with dementia. At the time of our inspection, 36 people were living at the nursing home.

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

The provider failed to meet regulations to ensure people were safe and had their needs met. Systems to ensure people were safeguarded from abuse had not been addressed by the provider. People were at risk of harm, systems to protect people were not always followed and were ineffective at identifying and managing these risks. People did not always receive their medicines safely and the guidance for their clinical needs was not always clear for staff. There were not always sufficient staff to ensure people received the support they needed in a timely way.

The management overview needed to be improved to ensure the principles of Mental Capacity Act (2005) were complied with, and staff knowledge and understanding improved. The new manager was ensuring staff updated their skills. People were supported to access the health care they needed. People had a nutritious diet, and they enjoyed the food offered. People had their needs assessed and the environment was adapted to meet their needs.

People and their relatives said they were supported by kind and caring staff. However, the provider did not always show compassion for people by ensuring there were sufficient staff to meet people's choices about when they received their support. Staff were kind to people, however people's privacy was not always upheld because staff did not always follow best practice.

The new manager was updating records to provide personalised guidance for staff to ensure people received person centred care. People had access to interesting things to do. The management team were recruiting for extra staff to improve people's well-being. People's end of life plans needed additional information to ensure they were up to date. Complaints were investigated, and outcomes actioned.

The service was not well led. The provider continued to not have effective governance systems in place to identify shortfalls in the quality and safety of the service for the third inspection in three years. The provider's governance systems had failed to ensure people were protected from the risk of harm, and that agreed safety measures were put in place. Systems to provide an overview of clinical governance were not effective because staff were not given time to complete checks. Actions identified were not consistently addressed, therefore there was a lack of continuous learning and improving people's safety and outcomes.

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 16 October 2018) and there were

multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to people's safety in protecting them from avoidable harm and to the quality and governance systems in place at this inspection. We found the provider remained in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

Follow up

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 to monitor progress. We 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?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.
Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.
Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.
Details are in our well-Led findings below.

Inadequate ●

Stretton Nursing Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection team consisted of an inspector and a Specialist Nurse Advisor.

Service and service type

Stretton Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. 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 of this information to plan our inspection.

During the inspection-

We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with fifteen members of staff including the operational manager, the manager, deputy manager, senior care workers, care workers and kitchen staff. 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 12 people's care records and multiple medication records. 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 quality assurance records.

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 requires improvement. At this inspection this key question has remained the same. 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; Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) 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.

- The provider had failed to ensure risks were assessed and people were protected from harm. For example, there were no risk assessments in place for people at risk of absconding to ensure there were systems in place to prevent potential harm. Other key risks had not been assessed and plans put in place, for example, ensuring people remained healthy and safe from the risk of infection from the animals living at the home.
- The provider had not implemented learning from safeguarding concerns to protect people from harm. There had been at least three recent occasions where people living at the home had left the building without staff being aware. These people had fluctuating capacity and had been at risk of potential harm. However, strategies to improve the security of the building, that had been agreed with the Local Authority, had not been implemented by the provider. On the second day of the inspection one person left the building and was at risk of potential harm.
- The provider failed to give clear guidance for staff to ensure people were supported safely. For example, clear guidance was not available for safe catheter care, diabetes management and records missed information about one person's seizures. Where guidance was given to staff it was not always correct. We found on two occasions there was conflicting information about people's risks.
- Medicines were not always managed safely. For example, topical medicines were not always monitored to ensure they were applied. Medicine records were not maintained to ensure people had their medicines as prescribed. For example, there were missing pictures of people to ensure the correct people received their medicines as prescribed.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider responded on the second day of the inspection and the front door was made secure. The

manager also completed the missing risk assessments to ensure there was guidance in place to mitigate the risk of harm for people living at the home.

- We found trained staff followed safe practice when administering tablet medicines and competencies were completed to ensure staff there were systems in place for safe storage and disposal.

Staffing and recruitment

- There was not always sufficient staff on duty to meet people's needs in a timely way. People and their relatives said there were usually sufficient staff on duty keep people safe. However, staff said there were not always enough staff to provide support at appropriate times. For example, staff said some people had their wash early in the morning or in the afternoon because they were unable to provide the right level of support at peak times to everyone living at the home.
- We saw staff had documented personal care was completed for some people at 5:30 in the morning, and for others in the afternoon.
- We spoke with the manager and they were working on a new tool to review the support needed by people throughout the day, which had identified additional staff were required in the mornings. The manager said when needed they used regular agency staff to ensure there were sufficient staff. There was an on-going recruitment campaign to fill vacancies.
- Staff we spoke with told us they had provided references and there were checks in place to ensure they were suitable to be employed at the service.

Preventing and controlling infection

- Measures were in place to control and prevent the spread of infection. Staff completed training and were knowledgeable about the requirements. The manager was aware that improvements were needed to ensure the environment met the guidelines. There were regular audits to ensure standards were maintained.
- There were cleaning schedules in place to ensure staff followed best practice.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 Act 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider had failed to ensure people's rights under the mental capacity act were fully promoted. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found some improvements had been made and the provider was now meeting the requirements of Regulation 11. However, further improvements were needed to ensure people's rights were consistently promoted.

- The management team had identified capacity assessments and best interest decisions were not always recorded correctly. The manager and deputy manager were in the process of reviewing people's records to ensure capacity assessments were decision specific and completed to a consistent standard for everyone who needed one.
- All the staff we spoke with had a good understanding of the principles of the MCA and people were supported wherever possible to make their own decisions, in line with the MCA principles.
- DoLS applications had been made when required. Any conditions associated with their DoLS authorisation were identified in people's care planning and there was clear guidance for staff to understand.

Staff support: induction, training, skills and experience

- The management team had identified there were gaps in staff knowledge and had arranged training updates to ensure staff remained skilled to meet people's needs. The management team had updated the induction program and agreed this needed to be linked to the care certificate.
- Staff told us they had completed training when they first started their role. They were supported by experienced staff who shared their knowledge of people's needs and best practice skills. One staff member we spoke to was new to care yet had a thorough knowledge about people's care needs and good practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were assessed prior to coming to the home and this formed the basis for the delivery of their care.
- Staff used nationally recognised tools to assess risks of pressure ulcers, nutritional risk and falls risks. The manager agreed to look at nationally recognised pain assessment tools to support staff to recognise people's potential pain.
- We saw information on best practice guidance was available for staff.

Supporting people to eat and drink enough to maintain a balanced diet

- At our last inspection we found people were not always monitored effectively to prevent malnutrition or dehydration. At this inspection we found everyone had food and fluid charts in place to monitor their intake, these were reviewed daily by the nursing staff on duty. The manager agreed to review this practice and only put charts in place when intervention was needed, to ensure monitoring was effective and targeted with outcomes clearly recorded.
- People we spoke with said the food was good and they had choice and could have more if they wanted. We saw people were offered choices with their meals and if people wanted something different they could just ask.
- People were offered drinks and snacks through the day and enjoyed their meal time experience.
- The cook was aware of people's needs and ensured there was suitable food provided.

Adapting service, design, decoration to meet people's needs

- The premises and environment were designed and adapted to meet people's needs. Corridors were wide enough for easy wheelchair access.
- There were adaptations to support people's needs such as clear signage to identify key areas for people living with dementia.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care

- People could access healthcare services when they needed.
- We saw appropriate referrals were made to support people with their health needs.

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had not always understood the importance of ensuring that staff have the time to provide compassionate support when people needed it. Staff did not have time to sit and talk to people for any meaningful length of time during the mornings. Staff were supporting people with their personal care in the early hours of the day and in the afternoon because there was not time to provide everyone with this support in the morning. Staff told us there were insufficient staff available in the morning on a daily basis to ensure people could choose when they wanted to be washed.
- People we spoke with told us all staff were kind and caring. One person said about staff, "They are all so lovely and will do anything for you."
- Staff demonstrated sensitivity and consideration about issues around equality, diversity and human rights. Staff were quick to pick up on non-verbal messages from people and react to them, for example a member of staff noticed a person needed extra help and they were quick to offer the extra support discreetly. We saw examples of staff being kind and caring throughout the inspection.
- Relatives said staff knew people well and were very kind and patient. One relative told us how staff always made them feel welcome and listened to any worries.

Respecting and promoting people's privacy, dignity and independence

- People did not consistently have their dignity respected. We found systems the manager had put in place to ensure rooms were not entered when personal care was being delivered were not consistently used. The manager had provided signs to be put on doors however we saw staff did not always use these. We also saw some staff entering bedrooms without knocking to respect people's dignity.
- However, people told us staff respected their privacy and dignity and supported them to be as independent as possible. One person explained they could go outside in the garden whenever they wanted and they enjoyed the freedom to do this.
- We did see some staff were careful to close doors when assisting people in their own rooms and knocked on people's doors before entering. People's dignity was maintained when staff supported people to mobilise.
- Staff were respectful of people's needs, for example making sure they were at the same level as people when they spoke with them.

Supporting people to express their views and be involved in making decisions about their care

- Staff asked people what they wanted to do and offered choices to meet people's needs. We saw examples where staff intervention reassured people and improved their well-being.

- People we spoke with said they made decisions about their day to day care and had the support they needed. We saw people were supported to make their own choices.
- The manager had set up meetings for people and their families to attend to gather their views and ideas for improvements. These were not fully established, and the manager was looking at ways to promote greater attendance. People were asked for feedback about food options and to plan interesting things to do, to ensure they were happy with the choices available.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People were happy with the care they received, staff knew them well and worked hard to provide quality care. However, at times through the day there were insufficient staff to ensure they were responsive to people's needs and to ensure staff had time to spend with people to provide quality care that wasn't task focussed.
- The management team had identified that care planning documents were not suitable to support staff to provide person centred care. The new manager had updated records and was in the process of consulting with people, staff and families to ensure they were up to date and clear for staff to follow. Regular staff had the knowledge to provide personalised care. People said staff knew them well.
- Regular staff knew how to communicate with people to understand their wishes and when people were less able to communicate verbally, we saw some staff observed people's facial expressions to gauge their preferences.
- People and their families told us support was adapted to meet people's needs.

End of life care and support;

- Staff were knowledgeable about meeting people's needs at the end of their life. One member of staff told us there was good support from professionals when people were at the end of their life. Records did not always capture people's wishes for at the end of their life. The new manager was in the process of updating these records.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The management team were aware of the accessible communication standards and we saw there was clear direction to staff about people's communication needs.

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

- People said they sometimes had interesting things to do to pass the time. One person told us, "I'm not bored." We saw examples of group activities arranged that people told us they enjoyed.
- We spoke with the activities co-ordinator who spent regular time with people either one to one or in groups, doing interesting things people liked to do. For example, craft activities, hand massages and

reminiscing. However, there were vacancies currently being advertised to increase the staff available to provide this support.

Improving care quality in response to complaints or concerns;

- People and their relatives said they could complain if they needed to. One relative told us they were waiting for an issue they had raised to be resolved. We saw where complaints were made these were investigated and the complaints policy followed by management team.

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 deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. The provider had failed to comply with regulation 17 for the last three inspections which is a continuous significant shortfall in the service leadership.

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

At our last inspection the provider had failed to have robust systems in place to ensure quality care was provided and identify shortfalls. This was a breach of regulation 17 (Good Governance) 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 provider had failed to identify shortfalls in the quality of care provided. For example, we saw the provider had visited the service regularly to look at records yet had failed to identify faults that were later found when the then registered manager left. For example, poor care planning documents and capacity assessments.
- The provider had failed to take action when shortfalls were identified by other professionals. For example, the front door closure agreed with the safeguarding team, and the clinical commissioning group's recommendations relating to infection control. Also, improvements identified by the provider's own quality assurance had not been actioned.
- The provider failed to have systems in place to oversee the clinical governance at the home. For example, we found gaps in topical cream management which meant people may not have been having their topical medicines as prescribed. Also, we found mattress settings at the wrong pressure which put people at risk of sore skin. There was also a lack of clinical oversight into care planning, such as catheter care, which put people at risk of infection. People were at risk because the systems in place failed to identify the clinical improvements needed.
- The provider's governance systems failed to identify gaps in records to ensure people were receiving the support they needed. For example, all the records we looked at showed no people received support with their oral care at night. Staff said they supported people with oral care at night, however this was not recorded on care records. The provider did not have effective systems to monitor people were receiving quality care.
- The provider had not ensured there were sufficient staff to meet people's complex needs in a timely way. Staff told us they required more staff on duty in the morning. The manager confirmed they had looked at

staffing levels and had identified the need for additional staffing in the morning. Records confirmed some people at the home were supported with personal care early in the morning or in the afternoon. The provider had not identified the shortfall or actioned the feedback from their staff and the new manager.

This was a continued breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17: Good governance. There was continuous systemic failure in the effectiveness of governance systems. This was the third inspection in three years where there was a continuous breach in this regulation.

How the provider understands and acts on their duty of candour responsibility:

- Relatives were confident they would be notified if there were any concerns about their family member. Relatives confirmed they were told when there had been a fall, or their family member was unwell.
- The new manager understood they needed to be open and honest and contact families when mistakes happened. We saw the new manager was putting systems in place to ensure this requirement was consistently completed.

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

- Meetings for people using the service and for relatives were held with the new manager, and relatives said they were confident the new manager would lead on improvements.
- Staff told us they had meetings with the new manager and felt like they were now being listened to. Staff were waiting to see if the new manager would drive through improvements, specifically around staffing levels in the morning.
- The management team acknowledged they had a long way to go to make all the improvements they needed. They had started working on an action plan to improve staffing levels and records and address other areas of shortfalls in the service.

Working in partnership with others.

- The new manager identified that they needed to link with other managers and the Local Authority for up to date guidance and best practice.

This section is primarily information for the provider

Enforcement actions

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

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

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider's governance systems and processes continued not to be as effective as they needed to be.
Treatment of disease, disorder or injury	

The enforcement action we took:

Requirement notice