Roseberry Care Centres GB Limited

Stephenson Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 17 October 2017 and was unannounced. A second day of inspection took place on 18 October 2017 which was announced. On the 18 October 2017 we served a letter of concern and followed this up with a third, unannounced day of inspection on 24 October 2017.

We last inspected Stephenson Court on 6 July 2017 and found it was meeting all legal requirements we inspected against. We rated the service 'Good' in all domains. At this inspection we found the provider was failing to meet legal requirements and we have rated the service 'Inadequate'.

Stephenson Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Stephenson Court accommodates 46 people in one building and at the time of the inspection there were 32 people using the service.

The service did not have a registered manager. The current manager had been in post for 11 months at the time of the inspection. Following the inspection the provider informed us the manager had left the organisation.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the provider had breached regulations in relation to safe care and treatment, dignity and respect, consent, meeting nutritional and hydration needs, staffing and good governance.

There were widespread and significant concerns about the leadership and management. . Quality assurance systems had not been followed, so areas for improvement had not been identified.

The concerns we found during the inspection had not been recognised by the manager or area manager and no action had been taken to improve the quality of the service.

Care documentation was not accurate, up to date or sufficiently detailed to ensure people received care that was appropriate and safe. Care plans had not been updated in response to people's changing needs, nor had they been appropriately reviewed. Some risks had not been identified and assessed. Other risks had been identified but records contained inaccurate information or failed to mitigate and manage concerns.

We found nurse call bells looped behind furniture in the first floor lounge which meant people could not readily summon support. Items of furniture had been placed in front of the internal fire doors. This would have prevented closure had the fire alarms sounded. Dental cleaning products, uncovered razors and out of

date prescribed creams were not securely stored in people's rooms.

People's nutritional and hydration needs had not been appropriately assessed. Care records contained contradictory information about people's diets and fluid intake that placed them at risk of harm.

There was evidence of involvement from external health care specialists. However, the advice and guidance they gave was not always included in care records or followed.

People's medicines were not managed safely. Protocols were not in place to ensure 'as and when required' medicines were administered appropriately. There was unsafe recording and we could not be sure people had creams applied as prescribed as there was no documentation in place.

People were not supported to have maximum choice and control of their lives and staff did support people in the least restrictive way possible; the policies and systems in the service did not support this practice.

People were not always treated with dignity and respect. There was limited evidence of involvement in care planning by people and/or their families and loved ones.

Staffing levels were based on the number of people living at the home and did not take account of people's needs and dependencies. Staff told us they did not have time to meet people's needs.

Staff had not received the appropriate support, supervision and training to enable them to care for people appropriately. There was no information in relation to nurses competency in relation to catheter care, specialist feeding techniques or wound care.

We have made a recommendation about the environment and meaningful activities for people living with a dementia.

Staff knew how to report any concerns in relation to safeguarding and people told us they felt safe and cared for.

Complaints were logged and were being investigated.

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

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take

action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks had not been appropriately assessed, and in some instances risks had not been identified.

Medicines were not managed safely.

Staffing levels were a concern and staff told us they did not have time to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act (2005) and associated code of practice were not followed or understood.

Staff did not have the required training and support to enable them to meet people's needs safely.

People's nutrition and hydration needs were not met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

There were significant shortfalls in the service which meant we could not be confident of the caring nature of the provider.

Most people and their relatives told us they were well cared for.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were out of date, contradictory and had not been reviewed in response to people's changing needs.

Care plans were not sufficiently detailed to ensure safe and

appropriate care and support was provided.

Activities were limited, and the activities co-ordinator spent the majority of their time assisting staff with the provision of care.

Investigations into complaints about staffing and care were ongoing.

Is the service well-led?

Inadequate

The service was not well-led.

There were widespread failings. The quality assurance and governance procedures had not been implemented or followed to ensure shortfalls were identified and action taken to improve things.

Audits had not been completed in a timely manner to drive improvement.

There was a failure to ensure accurate and complete records were maintained for each person living at Stephenson Court.

Stephenson Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 October 2017 and was unannounced. This meant the provider did not know we would be visiting. A second announced day of inspection took place on 18 October 2017. We also completed a site visit on 24 October 2017 which was unannounced.

The inspection was prompted in part by a notification of an incident following which a person using the service may have sustained a serious injury. This incident is subject to criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of skin integrity and pressure sores. This inspection examined those risks.

The inspection team was made up of two adult social care 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioning and safeguarding teams and the Clinical Commissioning Group. We also contacted the local Healthwatch, an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people living at the service and three relatives. We also spoke with the manager, the area manager, three nurses, three members of care staff, the activities co-ordinator, the housekeeper, a kitchen assistant and the chef.

We reviewed six people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records for nine people records relating to the management of the service.

We looked around the building and spent time in the communal areas. 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.

Inadequate

Is the service safe?

Our findings

During the inspection we looked at how risks were assessed and managed. We found a lack of risk assessments which placed people at significant risk of harm. Some people had complex needs, such as living with a dementia, nutritional needs, including the risk of choking and aspiration, skin integrity needs and specific medical needs. Risks associated with their conditions had not always been assessed and where risks had been assessed documentation was contradictory and unsafe. For example, we found three people who required a specific consistency of food who were deemed at risk of choking. The care records we examined did not contain risk assessments for choking. Another person had an assessment which indicated their swallow was normal but they also had an assessment which stated they had swallowing difficulties and were at risk of choking. This meant we could not be sure of the level of risk or how this was being managed.

Risks associated with poor hydration had not been adequately assessed. Whilst fluid intake was being recorded, there was no reason as to why nor was there any action taken if people's fluid intake was low. This presented a risk of dehydration.

Another person was living with diabetes and we found no information with regards to assessing the risks associated with diabetes, such as foot care and eye care. Foot and eye care is vital for people living with diabetes in order to reduce risk factors. Another person with specific medical needs in relation to a respiratory condition did not have relevant risk assessments completed.

We saw bed rail risk assessments did not assess the risk of people climbing over the bed rails. One person had a care plan which identified that bed rails should not be used due to the risk of this occurring, but bed rails were used. Their risk assessment did not include risks associated with climbing over the bed rails.

One person with complex nutritional needs had no risk assessments at all. Another person with a complex skin condition had an assessment for pressure care which assessed them as being at very high risk of developing issues with skin integrity. At the time of the inspection there was no record of monthly reviews having taken place after May 2016. Evidence of monthly reviews of skin integrity were provided following the inspection.

Staff used the 'React to Red' protocol for the observation of people's skin which sets out what staff have to do in case of changes in people's skin integrity. Whilst staff were recording reddening of people's skin, there were no records to indicate that staff had followed the protocol appropriately.

Assessments detailed contradictory information in relation to positional changes. Some people had documentation which evidenced they required four hourly positional changes and also had a document which stated two hourly changes. Records showed that for a period of six days one person was spending up to 12 hours a day lying on their back. During the inspection they were seen to spend the majority of each day seated in an easy chair. These actions would significantly increase the risk of pressure damage.

One person with a catheter was found to have their catheter bag positioned at a level which would increase

the risk of poor drainage. We also identified risks relating to poor wound care. Records were not well maintained so we could not identify when people's dressings had last been changed and whether or not the wound had been reviewed and was healing appropriately.

Accidents and incidents were recorded and some analysis had taken place. However, we saw two incidents where people had presented as challenging to staff. The incidents had resulted in physical harm to the staff member. The manager and the area manager were asked about the action taken to support the person and minimise the risk of repeat incidents. They were unable to source any other information and could not identify who the person was. They were unable to confirm if incidents of behaviour which challenged had been risk assessed and were being appropriately managed.

The contradictions within people's assessments meant there was a failure to accurately assess and mitigate risks which placed people at risk of harm.

We looked at how medicines were managed. We found anomalies in all the medicine administration records (MARs) we examined. Handwritten entries detailing medicines, timings and dosage prescribed had not been signed by two nurses. This meant there were no checks of the accuracy of the recording and no accountability. We found gaps in recording so it was unclear whether people had been given their medicines or what the reason for this was for the person not taking their medicine. One person had not received any of their prescribed medicines for a period from the night of 14 October 2017 to lunch time on 17 October 2017. The nurse said, "That was because they had been ordered but not delivered." No action had been taken to source an emergency prescription for the person. No medical advice been sought in relation to any impact on the person's health and well-being of the medicines being missed. Another person had had a change in the dose of their medicines. The appropriate medicine had been received but not placed in the medicines trolley and as such had not been administered. It had been recorded that the medicine was 'out of stock.' Another person had a box of tablets however this medicine was not recorded on their MAR chart. This meant we could not be sure whether the person was currently prescribed these medicines or whether they had been administered.

Two people were prescribed anti-coagulant medicines, which are used to thin the blood. Robust risk assessments were not in place to mitigate against the risk of excessive bleeding. There was also no detail about the action staff should take if the person was injured in any way.

Where people were prescribed 'as and when' medicines, no protocols were in place to support staff with decision making as to whether the person required the medicine. Protocols are used to record specific administration guidance in relation to time between doses and the maximum dose in 24 hours. They also record any behaviour people may display to indicate they require their 'as and when' medicine. For example, pain relief or medicines to reduce anxiety.

We found some people had been prescribed creams by their doctor. Some people did not have a Topical Medicine Administration Record (TMAR) and other had blank copies which did not detail their name, the prescribed cream or method of application. This meant there were no records kept of whether people were receiving their creams as prescribed. TMARs are used to record the application of any prescribed creams.

Bottles of prescribed liquid medicines were not routinely dated on opening. This meant we could not be sure they were within their shelf life. We found a large stock of old medicines within the treatment room, including the medicines for people who had passed away and some which had been prescribed in 2016. There was an excessive stock of insulin pens in the refrigerator used to store medicines. One box was opened, with no date of opening. The nurse said, "There are no permanent nurses on nights so day staff are

doing all the returns and check-ins, so returns aren't always happening."

There was a failure to ensure medicines were managed, stored and administered safely and in line with the prescriber's instructions. There was a failure to follow NICE guidelines in relation to managing medicines in care homes.

The treatment room on the first floor was chaotic and poorly organised and there was a poor level of cleanliness and hygiene within the room. On day one of the inspection we found the medicine trolley on the ground floor had been left unattended. The trolley was open with the keys in the door. This meant people, staff and visitors had access to medicines which may have placed them at risk of harm if ingested.

On the first day of the inspection we found two tubes of denture cleaning tablets in a person's en-suite bathroom, along with two razors. These were not stored safely and presented a risk. There was an open tube of prescribed cream dated December 2016. We made the manager aware and asked for the items to be removed. We found the items had not been removed at the end of the first day of the inspection and again informed the manager who advised they had asked a nurse to action this. On the second day of the inspection we found the tubes of denture cleaning tablets and razors were still in the en-suite along with a different unlabelled open tube of prescribed cream. We again informed the manager who accompanied us to the en-suite and removed the cream, denture cleaning tables and razors. The manger told us, "I had removed the cream; I can't believe they have not removed these after I asked again." This meant people had access to substances, which if ingested are hazardous to health. On the third day of inspection a razor, with no safety cap, was found on top of the person's bathroom cabinet, again presenting a potential risk.

During the third day of the inspection we observed a staff member stumble over a mobile hoist which had been left in the corridor. By leaving a piece of equipment unattended in the corridor this posed a potential hazard to people using the service, as well as staff and visitors.

Each person had a personal emergency evacuation plan (PEEP) which contained details about their individual needs should they need to be evacuated from the building in an emergency. We noted that where people had complex needs these were not entered on the PEEP. For example, equipment necessary to maintain respiratory and nutritional needs.

We concluded that care and treatment was not being provided in a safe way. These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

People and their relatives had mixed views about staffing levels. Three people said there should be more staff, one person said, "I think there should be more staff." One relative said, "The only thing I would say, and it's not their fault, there should be more staff." Another relative said, "The staffing levels could be better because if there's sickness it can be a problem." A third told us, "The care seems good but there is not a lot of staff, I've noticed buzzers sound for a while before they're answered." All the staff we spoke with felt the home was short staffed. They raised concerns about the lack of permanent nursing staff. Rotas evidenced that agency nurses were covering night shifts so there would be a reliance on care records which we identified did not reflect people's current needs. These concerns were raised with the manager and area manager.

We asked staff if they had time to spend time with people. One staff member told us, "No, we do all their personal care but I feel that's rushed. Most people upstairs are hoisted and need two (staff)." Another said, "I sometimes feel overwhelmed. We can't tend to everyone's needs because we have not got the time." Staff

told us they did not always have the time to bathe and shower people when they requested it. One person had spilt a drink on their top and it took some time for the staff to support the person as they needed two staff to support with mobility and only one was available.

We noticed nurse call bells were not responded to quickly. One person's nurse call sounded from 09.01 to 09.17 until we raised concerns about the length of time it had been sounding. The same person reactivated their nurse call at 09.18 until 09.22 when the nurse attended to the person. This meant the person had waited a total of 21 minutes for a member of the care or nursing team to attend to their needs. We raised this with the manager who commented, "I've just done an audit of response times and it was fine."

Observations during the inspection were that people spent significant periods of time unsupervised in the lounges on both floors. On the last day of our inspection no care staff were visible on the ground floor, other than during meal times. The staffing levels at the time of the inspection were a nurse on each floor, a senior care assistant who worked across both floors, three care staff upstairs and two care staff downstairs.

We spoke with the manager about how staffing levels were assessed. They said, "It's done depending on occupancy so once occupancy is 35 there will be an extra care assistant day and night." This meant there was a failure to determine the number of staff needed to meet the care and support needs of people using the service and to keep them safe at all times.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

Staff we spoke with understood their responsibilities regarding safeguarding and told us they would report any concerns to the senior carer, nurse or the manager. Staff gave examples of types of abuse such as physical and emotional abuse. They described any changes they might notice, such as bruising or a change in someone's behaviour. A safeguarding log was in place and there was a summary of action taken in response to allegations, however not all the records were dated or signed.

People told us they felt safe. One person said, "I get well looked after, they keep me safe." Another told us, "Staff are generally on hand and that makes you feel safe." A relative said, "They keep me involved in what's going on and [family member] is absolutely safe here."

Recruitment records showed that the recruitment process helped to protect people from abuse. Staff completed an application form and appropriate right to work and identity checks were undertaken. Checks were carried out by the Disclosure and Barring Service (DBS). The DBS carries out checks on the suitability of staff to work with vulnerable people, supporting employers to make safer recruitment decisions. Nurse pin checks were completed regularly and were all in date. This meant there was a check of the nurses' registration to practice.

Inadequate

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. The manager had a log detailing the dates of DoLS applications and authorisations. We asked to see the letters of authorisations and the manager said, "They should be in people's care records." We explained that they were not. The manager was unable to locate the authorisations. This meant we could not be sure appropriate and current authorisations were in place or if any conditions on authorisations were being met.

Care staff we spoke with were not aware of who had a DoLs in place. They had no clear understanding of what the MCA was. One nurse we spoke with was not aware of how to manage mental capacity assessments and did not know how to carry out a best interest decision meeting.

One person had a medicine care plan which advised their medicines could be given covertly and put into food. There was no evidence of a best interest decision having taken place and no evidence that the decision had been made in line with the principles of the MCA.

We saw one person who was in bed with bed rails in place. They appeared distressed and confused so we requested the manager support the person. They had care plans which stated bed rails should not be used due to the risk of climbing over them and a bed rails risk assessment which stated bed rails should be used. The risk assessment had failed to assess the risk of the person climbing over the bed rails. This meant the person had been placed at risk of harm, and had potentially been unlawfully restrained. We raised this as a safeguarding concern and discussed the care documentation with the manager. The manager rewrote the person's care plan however it made reference to the person becoming agitated and frustrated and stated, 'At these times staff should not put me into bed as this presents a higher risk of injury if the bed rails are erected.' This meant the manager had written a care plan which actively deprived the person of their right to go to bed if they were presenting as being agitated or frustrated. It displayed a failure to manage the risk presented by the bedrails in favour of restricting the person's access to their bed.

The manager, through their actions, evidenced a lack of understanding of the principles of the MCA and the associated code of practice.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Need for Consent

We spoke with staff about the support and training they received. There were mixed views from staff about training. Comments included, "No training in challenging behaviours", "The online training is not the greatest", "I have not had any safeguarding training", and "My training is up to date". A nurse said, "I think I've done safeguarding" and "I had very quick training with the nurse (Nutricia) on how to set the pump up". This was in reference to Percutaneous Endoscopic Gastrostomy (PEG). PEG is a procedure where people receive nutrition through a tube in the stomach. Another staff member said, "There used to be lots of training in house previously and now it's all online, it's detailed but it's not the same as face to face."

We found staff completed on line training to cover several topics including health and safety, fire safety and infection control. Certificates were in place to demonstrate staff's completion and gave a percentage score from the training. The manager was not aware of how checks were made to see how staff that scored a lower percentage had an appropriate level of understanding. We found some scores were as low as 80%. One staff member told us, "I did care planning and got 57%."

A training matrix evidenced that no staff had attended training in dementia awareness, 34.48% of staff had attended pressure area care and prevention, 44% had completed MCA and DoLS training and 72.09% had completed moving and handling training. There was no information in relation to nursing staff competencies in relation to PEG care, wound care or catheter care.

When we asked staff about care of a PEG site and catheters, staff told us they had not had training in either of these areas. One staff member told us, "I was shown how to empty and drain the (catheter) bag but not actual care".

We asked nursing staff about their training and competency checks. One nurse commented they had training in venepuncture (to take blood or give injections), wound care and catheterisation a long time ago. No checks on their competencies to carry out these procedures had taken place.

We spoke with staff about the support and supervision they received. Staff told us, and records confirmed, that a staff meeting had been held in September 2017. Staff were not clear about the amount of supervisions they should receive during the year. One staff member told us, "I have had 1 – 1 with (senior carer) who gives me information." They confirmed this was not formally recorded. Another member of staff thought they received a supervision every six months, another told us they had had four supervisions in two years. Agency staff were not directly supervised by the management of Stephenson Court which meant their performance and practice was not being directly monitored. None of the staff we spoke with had received an appraisal. A supervision and appraisal matrix was in place but no appraisals were documented as having been completed. The manager provided us with some appraisals. However, they were incomplete and there were no action plans developed even if areas for improvement had been identified.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing

We found assessments and records pertaining to people's nutritional needs contained contradictory information. For example, one person's records stated they required two different types of diet, pureed and normal. This placed them at risk of harm due to receiving an incorrect diet. Another person had two diet notification sheets which were given to the kitchen to advise the catering staff of type of diet they needed. These gave differing information. We asked care staff about one person's diet and they said, "She is on a

normal diet." Another member of care staff approached and said, "I think it's a soft diet." We had observed this person was given fishcake, chips and mixed vegetables for a meal. We could not be sure staff knew the appropriate diet people should be receiving. The inconsistencies within care records meant they could not be relied upon to ensure people received the correct type of diet.

Where people had been assessed as needing a modified diet, there were no detailed plans and risk assessments had not been completed to assess the risk of choking and mitigate any concerns. Alongside the contradictory information in relation to nutrition and hydration, this placed people at high risk of receiving inappropriate meals which increased their choking and aspiration risk.

We reviewed a selection of food and fluid charts for people who were assessed as being at risk of dehydration or malnutrition. We found where target amounts of fluids were recorded, contradictory information was documented. For example, one person had a care plan which stated they needed 1000ml – 1500ml daily, but their continence assessment stated to encourage at least one to two litres per day. Monitoring charts were being completed, however they did not contain fluid targets to indicate to staff how much fluid a person should be drinking. Records of the amounts people had drunk during the day were not always totalled. There was no detail in relation to action to take if people's fluid intake was low. For example, one person had a target intake of 1000ml – 1500ml but during the week prior to the inspection they had only had between 330 and 800ml per day. This placed them at risk of dehydration and infection. We found there was no oversight or review of people's food and fluid charts. Where people had refused a meal or drinks, there was no further recording to show if staff had returned to offer further drinks or snacks or to try again with the offer of a meal.

For people who were living with diabetes, there was no information about providing appropriate diets. There was also no recorded guidance for people who were prescribed specific medicines which meant they needed to avoid certain foods. One person had complex nutritional needs but had no care plans or risk assessments in place. This meant there was no guidance for staff to follow in relation to their specific needs, thereby placing them at risk.

In response to our letter of concern to the provider, a clinical review of all people living at Stephenson Court was completed by the manager during this inspection. The aim of this was to determine which people had a specific need for their nutrition and/or hydration to be monitored. The review was very basic and consisted of a list of names, their level of dependency and the words fluid, hygiene and positional change next to their name. We spoke with the manager about why people needed their fluid monitored and they said, "I need discussions with the team. As nurses believe everyone should be on a fluid chart, they need to understand it's on a need only basis." The manager then confirmed they had completed the review with the deputy manager who had only recently commenced in post so did not know people.

We saw external healthcare professionals were involved in people's care, however the specialised guidance they provided was not always used to update care documentation. For example, one person living with diabetes had a hospital letter stating their blood glucose level should be checked four times a day. This information had not been used to update their care plan which meant the advice provided by the hospital may not have been acted upon.

There was a failure to follow NICE guidelines in relation to nutritional support for adults. This failure placed people at significant risk of harm.

These concerns were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Meeting nutritional and hydration needs

We found people were offered a varied diet and told us they enjoyed their meals. One person told us, "Oh I enjoy my food." Another said, "It's alright, I am never hungry." A relative told us, "The meals are okay." During a mealtime we observed staff supporting people in a safe manner; people were not rushed and were offered a choice of meals. Fluids were readily available throughout the meal and we observed staff serving tea, coffee and snacks during the day.

Requires Improvement

Is the service caring?

Our findings

We joined people for the lunch time meal. One person had been seated alone at a table and was facing the wall. We asked why they were seated in this position. One staff member told us, "[Person] throws things off the table so we sit them there." We noticed another person was seated in their arm chair in the dining room with a bed table in front of them. The person's meal was put on the table, however it was 10 minutes before staff moved the table close enough so they could eat their meal.

Privacy was not respected. When people were receiving personal care signs were attached to bed room and bathroom doors which advised everyone present in the home that the person was receiving personal care.

There was a failure to ensure a person's dignity and personal preferences were met. No equipment was available to support them to bathe and no attempt had been made to source appropriate equipment. The person had continuously been told, 'The bath is broken.' They told us, "I like a bath but I've never had one because they say the bath is broken." The manager confirmed it wasn't. Staff told us that baths and showers were not provided every day, or when people requested them, as they were too busy.

Some of the language used within care documentation was disrespectful and evidenced poor compassion and understanding of people living with a dementia.

These concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Dignity and respect

Some people and relatives were positive about the care provided at Stephenson Court. However, due to the widespread and serious concerns we could not be confident the provider's approach was caring.

People and relatives we spoke with were generally positive about the staff who provided their care. One person said, "I get on with them all, I get well looked after, they're all very caring." Another said, "They're all great, really helpful, really caring." Another person told us, "Some staff are okay but the relief staff don't seem to bother."

One relative said, "It's early days," they added, "I would say it's a three star home and it takes time to adjust as there's not so much individual attention."

One person told us, "I'm very well looked after here. I used to visit my friend and when I decided to give up my home I told the family this is where I wanted to be." Another person said, "I've never regretted coming in here because everyone is so nice and they do what they can to keep me going." A relative said, "[Family member] gets the best of care in here, whatever she needs she gets." Another relative said, "It's a nice atmosphere here." They added, "The staff are very caring, they treat everyone with respect."

We observed staff offered people the use of protection for their clothing during meal times. Where people needed support to eat and drink staff provided one to one assistance. They went at the person's pace,

ensuring they had eaten one mouthful before offering another. Staff used appropriate communication with people, for example, facial expressions, body language and gestures.

We observed caring interventions between staff and people. One staff member said, "Shall I give you a hand?" before sitting down to support them. Another staff member crouched down to the same eye level as the person before asking if they would like a drink. Where people needed equipment to eat their meals safely, this was provided. This included plate guards, adapted cutlery and straws to assist people to be independent when eating and drinking.

Care staff told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, explaining what was happening and gaining consent before helping them. We observed staff supported people with their mobility needs in an appropriate way when using equipment to move and assist.

People told us the staff listened to them and said they or their family were involved in their care plan. We saw limited evidence of people having signed to confirm they agreed with their plan of care.

Inadequate

Is the service responsive?

Our findings

We reviewed people's care records and found care plans did not contain the information needed to support people safely and appropriately. Care plans had not been reviewed regularly and were not updated in response to people's changing needs. They often contained contradictory information which placed people at risk of harm and inappropriate care.

One person who had been assessed as having continence needs had a care plan in place which stated they did not use the toilet but had their continence needs met by being hoisted on the bed. The information did not specify how to meet their continence needs. The continence assessment record stated they needed equipment to access the toilet and had been reviewed with the comment 'no change'. This meant the continence assessment was out of date as the person no longer used the toilet. This placed them at risk as staff may have followed the assessment and placed them on the toilet. There was no information within the file which gave any explanation as to why they could not access the toilet. For example, poor sitting balance.

Several people's care records contained conflicting information about when they required positional changes to relieve pressure. One person had a record which stated four hourly positional changes and another which stated two hourly. Positional charts identified the person was not receiving either of these interventions. For other people whose care plans stated they required positional changes staff told us, "No, they don't, I don't do them, they can move themselves."

One person had wounds which were being dressed by nursing staff. The person's care file did not contain any wound assessment records or wound care plans setting out the type of dressing used or the timings for the dressings to be changed.

One person had no care plans at all other than a 72 hour care plan which had been completed when they first moved into Stephenson Court in September 2017. 72 hour care plans were completed when someone first moved into the home to provide the staff with an initial plan of care. During these 72 hours detailed care plans and risk assessments should be developed.

Some people had complex medical needs, details of which were not included in their care plans. For these people there was no detail of the specialised equipment they used or how to care for and clean the equipment, such as PEG care or people who wore facial masks to support their breathing whilst they slept. Following the letter of concern we sent to the provider, we were offered reassurances that care plans were up to date. We reviewed them again on the last day of our inspection and found there remained gaps and inconsistencies. Advice on care and treatment provided by specialist units within hospitals and specialist nurses was not included within care plans, which meant people remained at risk of receiving unsafe care and treatment.

Mobility plans were in place which detailed any equipment staff needed to use to support people with their mobility. There was no detail for staff to follow on how to use the equipment safely or how to support the

person in their preferred way. It was noted that one person had a wheelchair for use in the community but this had not been assessed by an occupational therapist. We spoke with the manager about this as the person had been seen walking within the home without the need for any support. This meant the person's mobility had not been fully assessed.

There were no hospital passports evident which would support staff with the handover of important information about the person should they need to be admitted to hospital.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

An activities co-ordinator was employed however activities were restricted as they were observed to spend the majority of their time assisting staff with the provision of care. They also supported people during meal times. The activities co-ordinator told us, "Sometimes activities are affected, they are good for mental health but if someone needs the toilet you have to decide which." They showed us a monthly planner for activities, and we saw that weekly activities were repeated throughout the month. On day one of the inspection the planned activity was described as music therapy. We saw this was a karaoke DVD and some simple musical instruments which people were encouraged to use.

The activities co-ordinator explained they had a 'who am I' file which detailed the interests of each person. They explained how one person was an avid book reader but due to deteriorating sight they were having difficulty reading. The activities co-ordinator said they had organised some audio books for the person.

We observed people spent lengthy periods of time in the ground floor lounge area with no staff presence and no interaction. If people needed support or assistance their only means of seeking staff was to shout. There was no availability of sensory items for people and no entertainment other than the television. People's room doors were painted alternate colours but there was nothing to support people with orientation or reminiscence along the corridors.

We recommend the provider research best practice in relation to the environment and meaningful activities for people living with a dementia.

Two complaints had been logged since the last inspection. Acknowledgement letters had been sent which confirmed investigations were ongoing. A deadline for a response was shared with the complainant. We were unable to see outcomes or lessons learnt as the complaints were ongoing and had not yet been resolved. It was noted that one complaint was in relation to staffing levels and a decline in personal care over recent months.

Inadequate

Is the service well-led?

Our findings

The manager at the time of the inspection was not registered with the Commission but had been in post since November 2016. They had submitted several applications to register which had been rejected due to errors on the forms. Following the inspection the provider informed the Commission that the manager no longer worked for the organisation.

When we arrived to complete the inspection, the manager was out of the building at a meeting. We were told the deputy manager had a day off, the senior care worker was not in and the nurses could not be disturbed due to medicine administrations. The housekeeper supported us by showing us around the building and arranging access to care records.

During day one of the inspection we found specific concerns in relation to a lack of managerial leadership and oversight. There were numerous concerns about care documentation, including a failure to identify and assess specific risks, contradictory and out of date information, and a failure to act upon the advice and guidance of external health care professionals. In response we sent a letter of concern to the provider seeking assurances. These assurances were received on 19 October 2017 stating care records had been updated and now reflected people's current needs. On 24 October 2017 we reviewed the care records and noted that although there had been work completed on the documents we found continuing failures to assess risk, detail appropriate strategies to support people, and ensure healthcare advice was acted upon.

In addition, we found the clinical review of people's needs was not detailed or effective in identifying those people who needed specific monitoring of their care to be completed and the reasons why. The provider had also offered assurances that an unannounced provider visit would be made to the home and a report shared with the Commission within seven days. The provider report had not been received at the time of the draft inspection report being issued to the provider.

We spoke with the manager about quality assurance and governance. They provided us with some audits and a copy of the area manager's 'home visit report' which had been completed on 25 August 2017. This had identified some actions such as fluid input not being signed off and for the manger to audit on an ad-hoc basis; evacuation plans to be updated and a care plan review. The report and action plan had not been signed by the area manager or the manager, and there was no evidence that any actions had been completed.

We asked about the frequency of audits. The manager told us, "Infection control (audits) are three monthly, catering monthly." We saw a catering audit had been completed in August 2017 and an infection control audit in September 2017. There were no action plans and the audits had not been signed off by the manager. We asked about care file audits and the manager said, "Suck it and see really." We asked why no care file audits had been completed since before the last inspection. They said, "I know, it's because I've been at another home." They added, "I've been out of the home since June/July intermittently. Decisions were made by the provider as there's no senior team. I believe the problems have started here since I've been out of the home." They added, "The new deputy is proactive and is a nurse so has clinical knowledge

and a business focus." The provider confirmed that the manager had not been absent from Stephenson Court for an extended period of time. They told us it was for a few days to complete an investigation and then for a few days to support another home.

The manager said, "I do a manager's walk around, do residents look clean and cared for I check there are no toiletries lying in bathrooms: that all the staff are on duty." During the inspection we noted the walk arounds did not detail a review of environmental risks. We found prescribed creams, razors and denture cleaning tablets were accessible in one person's bathroom. This meant the walk around had not been effective in identifying concerns.

Medicines audits had been completed by the manager but they had failed to identify the concerns we found during the inspection. They said, "I do the medicine audits and I have identified some missing signatures." There was no evidence that any action had been taken to resolve this.

We asked the manager if there was a service improvement plan or action plan in place to drive improvement. They told us, "No, no I don't have one. I've used organisational safeguarding minutes as a plan."

The provider had a governance framework which specified the frequency of audits. For care plans and nutrition audits the frequency was meant be monthly. It stated, 'Priority to be given to complex individuals, falls, SOVA (safeguarding of vulnerable adults), skin integrity, weight loss, complaints.' It also identified the need for a quality assurance and development action plan, which should be updated monthly and reviewed and documented in monthly supervision between the area manager and home manager.

The manager had failed to follow the provider's governance framework as audits were not completed to the required timeframe. Where they were completed, they had not been effective in identifying areas for improvement. There was also a failure to ensure an action plan was in place.

This meant the provider and manager had failed to implement systems and processes to assess, monitor and improve the quality and safety of the services provided. This left vulnerable people, many of whom were living with a dementia and had complex care needs, at risk of receiving care and support which was unsafe and inappropriate.

The lack of oversight of care records had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service and staff. There was a clear failure to ensure accurate, complete and contemporaneous records for each person were maintained.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance

The manager described her role to us as having, "Overall responsibility and accountability for the home, safety, policy and procedures, due processes, anything new being implemented, keeping practice and legislation up to date." They explained their responsibility to the Commission as being, "To be open, honest, duty of candour, completing notifications for safeguarding, DoLS, deaths, anything affecting the running of the business." They said their biggest challenge was, "Moving the service forward, the quality of care and that staff take it on board."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure care and treatment was provided with the consent of the relevant person. There was a failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. There was a failure to assess and mitigate the risks to the health and safety of service users of receiving care and treatment.

	There was a failure to ensure the environment was safe for its intended use. There was a failure to ensure the proper and safe management of medicines Regulation 12(1) 12(2)(a)(b)(d)(g)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to meet the nutritional and hydration needs of service users. Regulation 14(1), 14(4)(a)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to effectively ensure compliance had not been implemented. There was a failure to assess, monitor and improve the quality and safety of the service. There was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. There was a failure to maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1) 17(2)(a)(b)(c)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	There was a failure to ensure sufficient number of suitably competent, skilled staff deployed to meet peoples needs. There was a failure to ensure staff received appropriate support, training, supervision and appraisal as necessary to enable them to perform their duties. Regulation 18(1) 18(2)(a)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.