Supreme Home (Essex) Limited

Stafford Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

Stafford Court provides accommodation and personal care for up to 29 older people and people living with dementia. 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.

Our previous comprehensive inspection to the service was on 12 and 13 October 2017. The overall rating of the service at that time was judged to be 'Good'.

This inspection was completed on 1 and 2 November 2018 and was unannounced. On 5 November 2018 the service's administrator was requested to provide additional documents to the Commission as part of the inspection process. There were 25 people living at the service.

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.

A registered manager was in post, however in September 2018 because of sick leave, the registered manager delegated the day-to-day management of the service to two senior members of staff who were promoted to the role of acting manager and deputy manager. 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.

Quality assurance checks and audits were not robust, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm and where their health and wellbeing was compromised. The management team of the service had not taken appropriate steps to ensure they had sufficient oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight at both provider and service level had impacted on people, staff and the quality of care provided. Therefore, the management team were unable to demonstrate where improvements to the service were needed, how these were to be and had been addressed; and lessons learned to ensure compliance with regulatory requirements and the fundamental standards.

Suitable arrangements were not in place to act when abuse had been alleged or suspected. Although people told us they were safe, people were not protected from abuse and avoidable harm.

The management team had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people using the service, we observed some interactions which were not respectful or caring and failed to ensure people were treated with respect and dignity. People were not always actively encouraged to make day-to-day choices and we were not assured that staff always understood the importance of giving people choices and how to support people that could not make decisions and choices for themselves.

The standard of record keeping was poor and care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's current care and support needs. Suitable control measures were not always put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, and risk assessments had not been developed for all areas of identified risk.

Although appropriate recruitment procedures were in place to check staffs' suitability to work with vulnerable people before they started work, improvements were required to make sure these were robustly completed for all staff employed to ensure safer recruitment practices. Not all staff had received a robust induction and the role of senior members of staff was not effective in monitoring staff's practice and providing sufficient guidance and support. Training and development was not sufficient in some areas to demonstrate that people's care and support needs were fully understood by staff and embedded in their everyday practice. Staff had not received regular supervision.

People's capacity to make day-to-day decisions had been considered and assessed. Nonetheless, improvements were required to ensure more significant decisions which had been made by staff were in people's best interests and clearly recorded the rationale for these decisions.

People's healthcare needs were supported and people had access to a range of healthcare services and professionals as required. The registered provider's arrangements for the prevention and control of infection at the service was satisfactory.

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 were not identified for all areas of risk. Risks were not suitably managed or mitigated to ensure people's safety and wellbeing and improvements were required relating to medicines management.

There was an inconsistent approach to safeguarding that put people's safety at risk and people were not protected from harm.

Suitable arrangements were not in place for reviewing and investigating incidents when things go wrong and lessons were not learned.

The deployment of staff was not always suitable to meet people's care and support needs and improvements were required to ensure staff spent time with people to talk and to engage with.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staffs' knowledge and understanding of training was embedded in their everyday practice. Not all staff had received a robust induction or regular supervision.

The dining experience was observed to be satisfactory, however improvements were required relating to how people's nutritional and hydration intake was recorded so that it could be determined if this was satisfactory or not.

Staff's knowledge and understanding of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] was basic and improvements were required to ensure capacity assessments were completed for all areas.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People using the service did not always receive good quality care or treated with respect and dignity. Care provided was primarily task focused and 'service-led' rather than person-centred.

Staff did not always effectively communicate with people using the service, particularly people living with dementia.

Is the service responsive?

Requires Improvement

The service was not consistently effective.

People did not always receive care and support that was responsive to their individual needs.

Improvements were needed to ensure all of a person's care and support needs was recorded and the information up-to-date and accurate.

People were not supported to participate in a range of social activities.

People and relatives were confident their complaints would be taken seriously and acted upon, however improvements were needed to show how conclusions had been reached and ensure all complaints acknowledged in line with the registered provider's policy and procedures.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to measure the quality of the service did not identify the concerns and risks to people that we found as part of this inspection.

Stafford 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 is 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.

The inspection was prompted in part following concerns raised by the Local Authority with the Care Quality Commission. The information shared with the Care Quality Commission indicated concerns about falls management, risks to people who have bedrails fitted, staffing levels and management oversight and this inspection examined those risks. Because of the Local Authority's concerns, an embargo on placements at Stafford Court was imposed by them in September 2018.

This inspection took place on 1 and 2 November 2018 and was unannounced. On 5 November 2018 the service's administrator was requested to provide additional documents to the Commission as part of the inspection process.The inspection team consisted of two inspectors on both days. On 1 November 2018 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other statutory notifications. This refers specifically to incidents, events and changes the registered provider and registered manager are required to notify us about by law.

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 spoke with 10 people who used the service, three people's relatives, six members of care staff, three senior care staff, the staff member responsible for facilitating social activities, the administrator, the deputy manager and the acting manager.

We reviewed six people's care plans and care records. We looked at the staff recruitment records for three members of staff, staff training information for the service, supervision and appraisal records for an

additional three members of staff. We also looked at the service's arrangements for the management of medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Not all risks to people's safety and wellbeing had been identified, and suitable control measures had not been considered and put in place to mitigate the risk or potential risk of harm for people using the service. Since July 2018 concerns had been raised by the Local Authority with the registered manager that not all bedrails were fitted with full length foam bedrail bumpers. At this inspection seven people's beds were observed to have bedrails fitted to their bed but continued to not have full length foam bedrail bumpers fitted to keep them safe. This meant people remained at serious risk of entrapment as they could place their feet or arms between the split rails. Following the inspection, the service's administrator confirmed via email that an order for full length foam bedrail bumpers had been placed on 5 November 2018.

On the second day of inspection one person was observed to have their bedrails up and in use throughout the day whilst they laid in bed. A crash mat was leaning against the wall on the opposite side of the room. The person's care file detailed they did not like to have their bedrails up and in use. The care plan and bedrail risk assessment stated a crash mat should be placed on the floor and close to the bed as they were at risk of climbing out of bed and the bedrails presented a higher risk. However, on the second day of inspection there were six occasions whereby the person's bedrails remained up and in use and the crash mat propped up against the opposite wall. Staff failed to notice this and to take appropriate action. Another person was observed to have their bed set at the lowest setting and their bedrails down whilst in bed. The person's care plan detailed it was not suitable for the person to have bedrails up and in use and a crash mat should be placed on the floor close to the bed to maintain their safety. Despite talking to a member of staff on duty and raising a concern about the crash mat being stored under the person's bed, no further action was taken until the inspector raised this with the acting manager.

On the first day of inspection we overheard someone calling out, "Nurse" and then, "Nurse, nurse, nurse." We went to investigate and found the person sitting on their bedroom floor, complaining of pain in their hip and back. Earlier in the day we noted this person had been sat in their comfortable chair but their call alarm facility was wound round their light fitting on the opposite wall over their bed. We used the call alarm to summon staff assistance and this arrived promptly. When discussed with the deputy manager as to why the person's call alarm was not in reach, they told us that the person had probably wound their call alarm around their light fitting, however several people's cords were like this. When we discussed this with the acting manager, they confirmed without hesitation that the person could not have done this. The person's care plan recorded their call alarm facility needed to be at hand always.

Fall audits for the period May 2018 to September 2018 confirmed one person experienced a total of 15 falls, some resulting in injury, such as skin tears or bruising. The care plan for this person stated to keep the person safe staff should always ensure they used their walking frame when mobilising. On the second day of inspection there were six occasions whereby the person was observed to mobilise independently without the use of their walking frame. On four out of six occasions, staff were not present and we had to intervene and ask staff to assist the person to mobilise safely. On two occasions, staff were observed to walk past the person without intervening and providing them with their walking frame.

The lack of consideration, monitoring and action by staff as detailed above, placed people at significant risk of harm and injury should they have attempted to climb or roll out of bed and where they were at risk of falls.

We looked at the Medication Administration Records [MAR] for 13 of the 25 people who resided at the service and found discrepancies relating to staff's practice and medication records. Additionally, not all medicines were securely stored. On the first day of inspection the member of staff administering the lunchtime medication round was observed to leave the keys in the lock of the medication trolley for a timed period of two minutes. One person's medicated cream which was used to treat bacterial skin conditions was found in one person's room on the second day of inspection. This meant medication could be easily accessed by others not authorised to do so. Although we brought the latter to the acting manager's attention and advised the cream should be stored securely, information received from the Local Authority six days after the inspection confirmed this medication was still easily accessible to others not authorised to have access.

Not all recommendations following a medication audit by the Clinical Commissioning Group NHS Pharmacy Technician in September 2018 had been addressed. Staff continued to use the incorrect code on the MAR form where medication is prescribed 'as required' medication [PRN]. Staff were using the code for 'refused' which is not an accurate representation. Handwritten entries on the MAR form were not consistently double-signed by staff. PRN protocols detailing the specific circumstances this medication should be administered were not routinely completed. There were gaps on the MAR form where staff had failed to sign to confirm the person had had their medication administered, however this was a recording issue as we found the medication had been dispensed from the blister pack. Medication audits were completed at regular intervals, however where corrective actions were required, an action plan had not been devised to evidence how these were to be addressed and followed-up. The inspection showed required improvements had still not been made and lessons learned.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a member of staff behaviour inappropriately towards a person using the service whilst attempting to administer their medication. The staff member was observed to go up to the person, clench their fist and to place this very close to the person's face whilst making a 'growling' noise. This incident was immediately reported to the acting manager and they were advised to submit a safeguarding alert to the Local Authority in the first instance. Although this was duly completed and the acting manager stated the perpetrator would be removed from administering medication, no further actions were taken or considered. This meant the risk to other people being exposed to inappropriate and abusive behaviours remained. The Local Authority investigated the safeguarding concern and this was closed as the person using the service did not want to take the matter further.

A review of this staff member's recruitment file was undertaken. This demonstrated a previous allegation of physical abuse was made in July 2018 to the registered manager regarding this staff member's practice. Information available demonstrated the registered manager had not robustly investigated the allegation of abuse or taken appropriate action following the incident in July 2018 to safeguard this person or others. Despite this the registered manager concluded the allegation of abuse was substantiated. The outcome stated the deputy manager was to monitor the staff member's performance for a period of four weeks. Information available showed the staff member's practice was not monitored and when discussed with the acting manager who was the deputy manager at that time, they could not remember if this had been completed or not.

Safeguarding concerns were not raised with the Commission in line with regulatory requirements or submitted to the Local Authority. For example, a safeguarding concern was raised by an external source to the Local Authority in September 2018, following an incident whereby a person using the service had left Stafford Court without staff's knowledge. The registered manager and acting manager failed to complete a statutory notification to the Commission in line with regulatory requirements.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records for three members of staff were viewed. Relevant checks were completed for two out of three members of staff before they commenced employment at the service. However, when checking the recruitment file for a member of staff who had left and returned to the service's employment after a five-month break, relevant checks relating to their employment had not been undertaken. A new application form was not completed, written references relating to the applicant's previous employment, proof of identity and a criminal record check with the Disclosure and Barring Service [DBS] had not been sought. A written record was not completed or retained to demonstrate the discussion had as part of the interview process. This showed robust measures had not been undertaken to enable the registered provider's representative to make an assessment as to the applicant's relevant skills, competence and experience for the role and if they remained suitable. We discussed the above with the member of staff and they confirmed the above was accurate.

Staffing levels as told to us by the acting manager were being maintained. Although, no negative comments were raised with us during the inspection relating to staffing levels and call alarms were answered promptly by staff when people requested assistance, the deployment of staff within the service was not always responsive to meet people's needs. For example, on the second day of inspection a person using the service was observed to call out intermittently over a 15 minute period as they required their comfort needs to be met. No care staff were present within the communal lounge and the person did not have access to a call alarm. We had to intervene and ask the kitchen assistant who was laying the dining tables to seek staff assistance as the person's behaviour became more insistent and distressed as the necessity for their comfort needs to be met increased. This was not an isolated incident.

Although people's dependency needs were assessed and recorded by the service's administrator, the dependency tool used did not consider the layout of the environment, people's social activities or social inclusion within the community nor planned absence of staff, such as known sickness, annual leave or staff training. The administrator confirmed the dependency rating for each person using the service was based on their knowledge of the person and not upon assessed data. This means there is a risk staff deployment at the service may be incorrectly assessed to meet people's needs.

The inspection highlighted the registered manager failed to identify and address safety concerns. When concerns are raised or things go wrong, the approach to reviewing and investigating the reasons was insufficient and slow; with little evidence of learning from these events. For example, not addressing the concerns raised by the Local Authority about people's bedrails, ensuring appropriate measures were put in place to safeguard people who were at risk of falls and addressing recommendations highlighted within the recent medication audit.

Appropriate arrangements were in place to manage the control and prevention of infection within the service. Staffs' practice was suitable, with staff following the service's policies and procedures to maintain a reasonable standard of cleanliness and hygiene within the service.

Requires Improvement

Is the service effective?

Our findings

A copy of the staff training plan was requested and provided, however initially this was not accurate and up-to-date. This was immediately reviewed by the administrator and a revised copy provided. The staff training plan confirmed not all staff employed at the service, including members of the management team, had attained up-to-date mandatory training in line with the registered provider's expectations. For example, one member of staff completed their manual handling training in September 2018, despite having been employed at Stafford Court for four months. The member of staff told us all other training was provided by members of staff and not through the service's formal training arrangements.

Observations showed some staff were effectively able to apply their learning, others were not and improvements were required to ensure their training was embedded in their everyday practice. Not all staff appeared to recognise their practice relating to interactions, exchanges and communication with people using the service, was not always appropriate or effective. These exchanges, were primarily routine and task-led. This referred specifically to the provision of drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs.

There was evidence to show staff newly employed had received an 'in-house' orientation induction. Staff told us the completion of the 'in-house' induction was a lot to take in and in their opinion, this had been rushed. Although the 'Care Certificate' or an equivalent formed part of the induction process for staff with no or limited experience within a care setting, this was not completed for one member of staff. This meant there was no evidence to show they had had their competency assessed against the core standards as outlined within the 'Care Certificate' or an equivalent robust induction program. Another member of staff stated they could not recall the specific details of their induction but remembered feeling, "Dropped in at the deep end" and their induction being relatively short. They continued to tell us, "I was really inducted by my colleagues and felt unsupported by the management." The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life. The member of staff had not attained a NVQ or QCF qualification or commenced and completed the Skills for Care 'Care Certificate.'

Most staff told us they did not feel supported or valued by the management team. Records demonstrated staff did not receive regular formal supervision and when it did take place, supervision consisted of staff being observed whilst undertaking a specific task, such as bathing or showering a person. For example, two members of staff had only received two supervisions in 2018. Another member of staff who had been employed in April 2018 had yet to receive formal supervision. This was not in line with the registered provider's supervision policy and procedure, which stated these were to be conducted at bi-monthly intervals. The latter was confirmed as accurate by the acting manager. The deputy manager confirmed they supervised staff but had not received any training.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments relating to meals provided were variable. One person told us, "Food's OK but not very

varied, they need a better cook, if I'm being honest." A second person told us, "The food is disgusting, for tea we've got tinned tomatoes on toast, but it's really like bread all soaked up in the juice. We had liver this week, couldn't eat it, so tough and the stewed beef was horrible. I don't eat it, but they [staff] don't comment, or offer anything else." A relative confirmed that they found the quality of the meat in meals provided for their member of family to be tough. They told us, "I'd like the chef or staff to try the food here."

Where people required assistance and support to eat and drink this was generally provided in a sensitive and dignified manner. People were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. However, one person was noted to be in their bedroom and seated in a comfortable chair. The person was fast asleep but on their portable table a plated meal had been provided. It was not possible to determine how long this had been there but the plate was cold to the touch and the meal no longer hot. A member of staff woke the person up but was advised to reheat the meal. It was unclear as to why the person had been given their lunchtime meal when they were asleep.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, referrals to a healthcare professional had been made. Where instructions recorded that people should be weighed at regular intervals, such as, weekly or monthly, this had been recorded and followed. However, it was not always possible to establish if people had received sufficient food and fluid on any given day so as determine if their diet was satisfactory.

The service worked with other organisations to ensure they delivered joined-up care and support. This included the dementia support team, District Nurse services and the local falls team. People suggested to us their healthcare needs were met and they received appropriate support from staff. One relative told us, "They [staff] will call the doctor if they are worried about [family member], for instance they called him in because [relative] had a nasty cough." Several people told us a GP surgery was held at the service every Thursday to check on people's healthcare needs and on the second day of inspection this was held. Care records showed people's healthcare needs were recorded, including evidence of staff interventions and the outcomes of healthcare appointments. However, prior to the inspection we were aware that one person had sustained three falls between December 2017 and April 2018 and it was found that medical advice had not been sought by staff at the earliest opportunity. This concern was raised and investigated by the Local Authority. The safeguarding outcome was substantiated.

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 the mental capacity to make 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.

Staff demonstrated a basic knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Information available showed people living at Stafford Court had had their capacity to make decisions assessed. Nevertheless, capacity assessments had not been completed where people had a bedrail fitted and in use or where an alarm mat was being used to alert staff if a person stood up from their chair or bed. Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation. However, people were not always supported to have maximum choice and control of their lives and staff did not support them in the least

restrictive way possible. Evidence to support this is detailed within other sections of the report.

Requires Improvement

Is the service caring?

Our findings

Overall people and their relatives told us that staff cared for people in a considerate and kind way. This meant that people were generally satisfied and happy with the care and support they received from staff. One person told us, "They're [staff] all pleasant, most of them I know by name. The other evening staff were going to KFC, and they popped in to ask if I wanted something, what a treat." Another person told us, "Most staff are kind, some are better than others. [Name of staff member] is the best one, I get very down and [Name of staff member] notices. Others don't always seem to understand, some make me feel I'm being a nuisance." Relatives confirmed they were happy with the care and support provided for their family member. One relative stated, "Staff absolutely love [Name of family member], they tell me they've always got a smile for them. I do feel they care for them well."

The above was inconsistent with our observations as most interactions by staff were task and routine led. This referred specifically to staff providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television and although this was on throughout the day, people using the service were predominately either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time and staff interactions did not always ensure people got the time they needed to respond before staff walked away.

We were not assured that staff always understood the importance of giving people choices and how to support people that could not always make decisions and choices for themselves. For example, people were observed not always being offered choice in relation to drinks. Not all people were able to communicate their specific wishes and preferences relating to the meal choices available, particularly people living with dementia. The menu for the day was displayed on a wall close to the kitchen. Although available in both a pictorial and written format, this was not easily accessible for people to see and the format was difficult to decipher. No other pictorial aids were available to enable people to make an informed meal choice and staff did not make the effort to find an alternative way to enable this to happen, such as physically showing each plated meal choice and asking the person to choose their preferred option.

On day one of the inspection whilst speaking with a person who used the service, a member of staff entered their room and offered to turn their light on as the room had darkened. The person stated, "I prefer the light off if you don't mind." The person was assured that this was their choice, despite the room being quite dark. After five minutes and other member of staff entered the person's room and turned the light on without checking if this was alright. When we advised the staff member of the person's preferences, they told us, "Well, I need to see them if I'm giving them their tablets, don't I." The staff member did not speak directly to the person providing an explanation for their actions, nor did they provide an assurance that they would turn the lights off again when they left.

The above demonstrated people were not always treated with respect and dignity. Staffs' communication with people living at Stafford Court was not always appropriate. Although some members of staff engaged appropriately, others used raised voices to communicate with each other across the communal lounge and

down hallways. Two members of staff were observed to provide manual handling support to one person. Whilst delivering this support neither member of staff spoke to them, did not gain their consent to undertake the task and spoke loudly over the top of the person's head to each other. Staff were also overheard to talk loudly and openly about people's comfort needs, such as, "Do you want the toilet [Name of person using the service]?" and, "I've got two more bums to do." This showed staff did not understand the need and importance of maintaining people's dignity and respect.

These failings constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's independence was promoted and encouraged according to their capabilities and abilities. People told us they could manage some aspects of their personal care with limited staff support. They also confirmed if they needed assistance this would be provided. The majority of people ate and drank independently. One person told us, "I get myself up and dressed, and get myself into bed at night, I live as independently as I can, but they're [staff] there if I need them."

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed there were no restrictions when they visited and they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported by staff in a way that met their needs or provided care that was responsive. Care provided was task focused rather than in response to people's individual needs and preferences. On the first day of inspection a person was overheard to call for staff on three separate occasions within 15 minutes. Although a member of care staff was within the communal lounge/dining area there was no initial response. When the staff member did realise the person required assistance, they were able to tell the staff member they required support with their comfort needs. The member of staff was overheard to sigh and told the person they would have to wait for two minutes. This person was observed to wait for between 20-25 minutes before appropriate manual handling equipment was brought in so that their comfort needs could be met by staff.

Care plans did not always fully reflect people's holistic care and support needs or provide sufficient guidance for staff as to how these were to be met. Improvements were needed to ensure care plans included accurate information relating to a person's specific care needs and the delivery of care to be provided by staff. For example, the care plan for one person referred to the person being at the end of their life. There was no end of life care plan in place and when we discussed this with staff we were advised they no longer were judged as requiring end of life care. The care plan had not been updated to reflect this change in the person's needs. The care plan for another person relating to their mobility needs recorded the person's risk of falls as having "decreased" but their falls risk assessment referred to an increase in falls. This provided contradictory information and anyone who did not know the person well could be confused because of the contradictory information recorded. The moving and handling information for one person mentioned they required a stand-aid hoist for their mobility needs, however staff were also observed to use a full hoist when the person was unable to weight-bare. The latter was not recorded within their care plan. This meant there was a risk that relevant, accurate and up-to-date information was not captured for use by care staff and professionals, or provided sufficient evidence to show that appropriate care was being provided and delivered.

People's comments about social activities provided were variable. One person told us, "I would never go out if my relative didn't sometimes take me out shopping, I look forward to that. I never join in any activities, they're not for me…..not much happens anyway." Another person told us, "I think the activities could improve, I've been a few times to bingo or painting, but it's not much fun. I like the singers [external entertainment] who come about once a month. I'd like them more often, we have crisps and wine when they come in." Staff confirmed improvements were required to ensure people using the service had their social care needs met but stated they did not have the time to provide this.

On the first day of inspection, no social activities were initiated or offered by staff and the person responsible for facilitating social activities was requested by the management team to accompany a person to hospital. The activities programme in the main communal lounge stated an art and craft activity would be undertaken during the morning and a 'sing-a-long' in the afternoon. This did not happen. On the second day of inspection the person responsible for facilitating social activities spent individual time with a small number of people who resided in bed and this was noted to be positive. At all other times there was an over

reliance on the television, but most people did not appear particularly interested in watching this. Only one person was consulted as to their preference of television programme regardless of others residing within the communal lounge. This meant people living at Stafford Court did not have the opportunity to participate in social and leisure activities of their choice and according to their personal preferences and wishes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service. One person told us, "I've never had any reason to complain, but I think they'd [management team] listen if I did bring something up. I would talk to the deputy manager." Records showed there had been three complaints since our last inspection in October 2017. A record was available detailing the specific nature of each complaint, however there was a lack of evidence to show how conclusions had been reached. Not all complaints had been acknowledged by the registered manager in line with the registered provider's complaint policy and procedure. A record of compliments was maintained detailing the service's achievements.

Staff confirmed no-one at Stafford Court was judged as being at the end of their life or required palliative care. Some people were noted to have a completed document entitled 'Information About Me'. This provided vital information for others about a person's health care needs and the care to be provided towards the end of their life. However, other than where a person wished to be cared for at the end of their life, information relating to people's end of life care needs and preferences had not been recorded. The care plan provided no evidence to suggest a discussion had been held with the person or those acting on their behalf to consider their preferences regarding the type of care they would wish to receive.

We recommend the registered provider seeks best practice guidance from a reputable source in line with current regulations relating to end of life care.

Inadequate

Is the service well-led?

Our findings

Since our last inspection to the service in October 2017, the management arrangements at Stafford Court had not changed. However, the Care Quality Commission was made aware by the Local Authority on 8 October 2018 that the registered manager was not currently managing the service and in the interim they had promoted two members of staff from within the service to manage Stafford Court. The deputy manager was promoted to the acting manager role and a senior member of care staff was promoted to the deputy manager position. The acting manager and deputy manager were both supported by the service's administrator. The acting manager confirmed the registered manager was normally in attendance at Stafford Court two to three days each week with the remaining time spent at the registered provider's 'sister' service. The acting manager went on to explain that the registered manager was primarily based in the office and this was confirmed as accurate by staff spoken with. Following the inspection the registered manager wrote to us and advised they were normally at Stafford Court four days a week and since 2009 visited the service at the weekend. This did not concur with our findings and what staff and people experienced during the inspection.

Although the registered manager can delegate responsibilities to others in their absence, neither member of staff was provided with a revised job description or received an induction to their new role to enable them to carry out their newfound duties effectively. Though the acting manager and administrator had attained an accredited Level 5 diploma in Leadership and Management relating to Health and Social Care, we had concerns regarding their knowledge, understanding and competence to effectively manage the service, particularly given the concerns raised by the Local Authority over the past four months and highlighted during this inspection.

There was no evidence to show the registered manager had provided adequate support to the acting manager and deputy manager since being promoted and they had failed to monitor the acting manager's performance or their effectiveness through formal supervision arrangements. The last recorded supervision on file for the acting manager was dated May 2018 and this was completed by the administrator assistant. This was not appropriate as they did not have the skills, competencies and experience to oversee the acting manager and to monitor their ongoing performance.

The administrator confirmed they were responsible for completing most of the service's audits and checks, particularly relating to health and safety, infection control, food safety and medication. The quality assurance arrangements failed to effectively measure the experience of people being supported and cared for at Stafford Court. This meant there was a lack of oversight based on observations of actual care being provided by staff and being experienced by people living at the service. The registered manager's quality assurance arrangements had failed to recognise and address staff's practice and competencies where concerns were highlighted about a member of staff's performance. Arrangements in place to effectively monitor the quality of the service to ensure the service operated safely and lessons learned when things go wrong were inadequate. Staff practices were not monitored to ensure people were always being treated with the utmost respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.'

The culture of the service was not positive and systems in place did not always promote a 'person-centred' culture that centred on people's needs or valued them as individuals. The care and support delivered by staff was not consistent to ensure people received safe care and support. This referred specifically to not enough had been done by the registered manager to address concerns already highlighted by the Local Authority, such as, obtaining full length foam bumpers for bedrails at the earliest opportunity, making sure falls management arrangements were effective, call alarm facilities not always accessible for people that required them to keep them safe and lack of meaningful social activities. The standard of record keeping was inconsistent and not being audited and monitored to ensure this improved. Robust arrangements were not in place to safeguard people from abuse and harm and the deployment of staff was not always responsive to meet people's needs and this impacted on the quality of care some people received. Not all staff had up-to-date mandatory training or received regular supervision.

It was apparent from our inspection that the lack of robust quality monitoring and auditing was a contributory factor to recognise breaches or potential breaches with regulatory requirements and to help drive and sustain improvement. The registered provider's last quality audit was for the period 1 January 2017 to 30 September 2017 and the last report completed by the registered provider's representative was dated March 2017. The administrator confirmed that as far as they were aware no others had been completed.

Staff did not feel listened to, valued or supported by the registered manager or acting manager. Staff told us they did not feel the service was well managed. Staff told us they relied heavily on the deputy manager as they found them to be more approachable than the registered manager and acting manager. The rationale provided by staff was there was a lack of consistent, clear direction from the management team, particularly as the registered manager's presence at Stafford Court was infrequent. The latter was also confirmed by people using the service and those acting on their behalf. Whenever people spoke to us about the management of the service, they referred to the acting manager and deputy manager by name, citing they rarely saw the registered manager. One person told us, "We don't see much of [Registered manager's name]. They float in from time to time and ask if anybody's got any complaints. I'd go to [Deputy manager's name] if I had any concerns, because we see more of them."

A significant number of staff spoken with were candid and expressed real concern regarding the management team's abilities, overall management style and the lack of effective leadership at the service. Staff were concerned about comments made getting back to the registered manager and acting manager as they were afraid of possible repercussions. Staff described a "bullying and blame culture." One member of staff told us, "[Name of acting manager] has a bullying attitude, when the inspection is over, we will be shouted at." The member of staff was asked to clarify this statement and explained that following visits by the Local Authority, staff were blamed for the findings and outcomes. Without an open culture the service cannot improve and it could place people are continued risk of receiving poor care because staff do not feel confident in speaking out when things go wrong. Staff expressed further concern that the lack of effective leadership and day-to-day management of the service impacted on the quality of care people received. For example, staff did not have time to support people who remained in their bedroom other than to provide "basic care." One member of staff told us, "Not enough time to spend with the most frail."

Statutory notifications and safeguarding concerns were not raised with the Commission in line with regulatory requirements or submitted to the Local Authority. Investigation reports were incomplete and provided a lack of detail relating to how outcomes had been reached and actions to ensure lessons learned and people were protected from risk and harm. The registered manager had failed to notify the Commission of their absence from Stafford Court for a continuous period of 28 days or to provide sufficient information as to the arrangements in place for the carrying on of the regulated activity during their period of absence.

Staff meetings had been held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Minutes of the meetings confirmed this and demonstrated the last meeting was held on 10 August 2018. Although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine how these were to be or had been monitored and the issues addressed. For example, the staff meeting held in May 2018 highlighted personal care standards for people using the service had dropped and some members of night staff had been using the service's computer for their own personal use, such as for personal internet shopping and inappropriate adult viewing sites. No information was recorded detailing how this was to be monitored and addressed. Meetings for people using the service and those acting on their behalf were infrequent.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives had been given the opportunity to complete an annual satisfaction survey for 2018. The administrator confirmed satisfaction questionnaires were sent out and three so far had been completed and returned.

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 9 HSCA RA Regulations 2014 Person-centred care Improvements are needed to ensure people using the service receive person-centred care that meets their needs. People's care plans accurately reflect their care and support needs and how these are to be delivered by staff.

The enforcement action we took:

Urgent Notice of Decision Imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Improvements are needed to ensure all people using the service are treated with respect and dignity at all times.

The enforcement action we took:

Urgent Notice of Decision Imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's care and support needs must be recorded and mitigated. People were not protected by the provider's management of medicines.

The enforcement action we took:

Urgent Notice of Decision Imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People must be protected from abuse and improper treatment and suitable arrangements

must be established and operated effectively and robustly to investigate any allegation.

The enforcement action we took:

Urgent Notice of Decision Imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised at both provider and service level.

The enforcement action we took:

Urgent Notice of Decision Imposed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Improvements were required to ensure staff receive a robust induction, training is embedded in their everyday practice and staff receive regular supervision.

The enforcement action we took:

Urgent Notice of Decision Imposed