Bupa Care Homes (CFHCare) Limited

Stadium Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 15 December 2016. At that inspection, we identified a number of Regulatory breaches and we told the provider that immediate improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and was placed into 'special measures'. We also placed a condition onto the provider's registration that prevented them from admitting new people to the service.

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.

We undertook this unannounced comprehensive inspection on 26 and 27 April 2017 to check that the required immediate improvements had been made. You can read the report from our previous inspections, by selecting the 'all reports' link for Stadium Court Care Home on our website at www.cqc.org.uk.

At this inspection, we found that some of the required improvements had been made. However, two of the seven previously identified breached of Regulations from the December 2016 inspection were still present and the service was rated as 'inadequate' in the well-led domain. As a result of this, the service will remain in special measures.

The service is registered to provide accommodation and personal care for up to 168 people. Care is delivered to people across five separate units. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection 130 people were using the service.

The home did not have a registered manager. However, the home manager had applied to be registered with us and their application was being assessed at the time of our inspection. 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 and associated Regulations about how the service is run.

At this inspection, we found that the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not being always identified and rectified by the manager or provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their care in accordance with their care plans. Medicines were not managed safely.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced.

Staff were not always effectively deployed to consistently meet people's needs and promote people's safety. People did not always receive their care in accordance with their care preferences and needs.

Staff were recruited safely and they knew how to recognise and report abuse. However, improvements were needed to ensure potential abuse was consistently reported in a prompt manner.

People were supported to access health and social care professionals in response to changes in their health and wellbeing needs. However, advice from professionals was not always followed in a timely manner to promote people's health, safety and wellbeing.

People were supported to eat and drink. However, people were not always supported to receive the specialist diets that they had been prescribed by health professionals. People who required specialist diets were not always offered the same level of food choices that people who required regular diets received.

Staff received some training to help them support people. However, there were significant training gaps that left people at risk of receiving poor, unsafe care.

Some staff knew people well which enabled them to have positive interactions with people. However, the information needed to provide consistent person centred care was not always recorded for new or temporary care staff to follow. People were not always involved in reviewing their needs and the information contained in their care records.

People were enabled to participate in indoor based leisure and social based activities that met their personal preference. However, further improvements were needed to ensure people could access outdoor spaces and the community when they wished to do so.

Most people described the staff as kind and caring. However, some people were concerned that staff did not always have the time needed to have quality, caring interactions with them.

There were gaps in end of life care training. However, systems were in place to enable people to receive pain free and dignified end of life care.

People's right to privacy was promoted.

The requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were followed to ensure people decisions about care were being made in people's best interests when they were unable to make these decisions for themselves.

Complaints were responded to and acted upon to improve people's care experiences.

There was a positive staff culture as staff were aware that there had been shortfalls in the quality of care. All the staff we spoke with told us they were committed to improving the quality of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Risks to people's health, safety and wellbeing were not always assessed, planned for, managed and reviewed to promote their safety.

People were not consistently protected from the risks associated with medicines and people could not always be assured that they had received their medicines as prescribed.

Staffing numbers had increased. However, staff were not always deployed effectively to promote people's safety.

Staff knew how to recognise and report abuse. However, improvements were needed to ensure potential abuse was reported in a prompt and effective manner.

Safe recruitment systems were now in place and people were protected from the risk of avoidable infections as staff knew how to prevent and control infection outbreaks.

Is the service effective?

Requires Improvement

The service was not consistently effective. Advice was sought from health and social care professionals in response to changes in people's health and wellbeing needs. However, advice from professionals was not always followed in a timely manner to promote people's health, safety and wellbeing.

People were supported to eat and drink. However, people did not always receive the diets they had been prescribed and people who required modified diets, were not offered the same choice and variety that people who required regular diets were offered.

Staff received some training to help them support people. However, there were significant training gaps that left people at risk of receiving poor, unsafe care.

People's consent was sought before support was provided. Staff understood and applied the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This meant people were supported to receive care that was in their best

interests when they were unable to make decisions for themselves.

Is the service caring?

Requires Improvement

The service was not consistently caring. Although improvements had been made, people's dignity was not consistently promoted. Most people described the staff as kind and caring. However, some people were concerned that staff did not always have the time needed to have quality, caring interactions with them.

People were not always supported to be involved in making choices about their care.

Some staff knew people well which enabled them to have positive interactions with people. However, the information needed to provide consistent person centred care was not always recorded for new or temporary care staff to follow.

There were gaps in end of life care training. However, systems were in place to enable people to receive pain free and dignified end of life care.

People's right to privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive their care in accordance with their care preferences and needs.

Some improvements had been made to enable people to participate in leisure and social based activities that met their personal preference. However, further improvements were needed to ensure people could access outdoor spaces and the community when they wished to do so.

Complaints were responded to and acted upon to improve people's care experiences.

Is the service well-led?

Inadequate

The service was not well led. Effective systems were not in place to consistently assess and manage risks to people's health, safety and wellbeing.

Changes had been made to the management structure at the service. However, these changes had not yet been effective in ensuring high quality care was consistently delivered.

People and staff reported some improvements had been made and staff told us they were committed to making the further improvements that were required.	

Stadium Court Care Home

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.

We undertook an unannounced inspection of Stadium Court on 26 and 27 April 2017. Our inspection team consisted of five inspectors, a medicines inspector, a specialist advisor with knowledge of skin care, a specialist advisor with knowledge of end of life care and two experts by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. At the time of our inspection, the service was under a large scale safeguarding enquiry (LSE) led by the local authority. This was due to a number of on-going safety concerns. We used feedback from LSE meetings, the public and the notifications we had received from the provider to formulate our inspection plan.

We spoke with18 people who used the service, 14 people who visited relatives at the service and a visiting health care professional. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with staff who worked at the service to gain their feedback about the care and to check they knew how to keep people safe and meet people's needs. We spoke with 21 members of care staff, seven nurses, an activities coordinator, a house keeper, five unit managers, the home manager and members of the provider's service recovery team.

We spent time observing how people received care and support in communal areas and 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 looked at the care records of 28 people to check they were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that improvements were needed to ensure that risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to receive or be at risk of receiving unsafe care.

Some relatives told us they had concerns about safety at Stadium Court. For example, one relative we spoke with told us they were very concerned about the number of injuries their relation had sustained as a result of a number of recent falls. They told us they felt that staff were, "Not assessing the risk". We found that people's risk of falling was not always effectively assessed, reviewed and managed as planned to promote their safety. People's care plans stated that their falls risk needed to be reviewed after every fall that they sustained. Care records showed that falls did not always trigger a review of the risk of further falls as planned. For example, on Stafford unit, one person's records showed they had fallen five times without their falls risk being reviewed. A review was only completed for this person after a fall resulted in a serious injury. This showed that people's risk of falling was not reassessed as planned in order to protect them from the risk of serious injury.

Some people's care records contained specific guidance for staff to follow to help manage their risk of falling. However, we found this guidance was not always followed. For example, on Stafford unit, one person's care records showed that they required supervision of staff to enable them to mobilise safely. Their care records also stated that assistive technology was required so that staff could be alerted when the person was attempting to move from their bed. This person's records showed that two of their falls this year had occurred when their assistive technology had not been plugged in correctly, which meant staff had not been alerted that the person was in need of supervision when they attempted to move from their bed. This meant the guidance in this person's care plan was not always followed by the staff to promote this person's safety.

Some people who used the service displayed behaviours that challenged, such as verbal or physical aggression. We found that these behaviours were not always managed effectively to promote people's safety and wellbeing as the risks associated with these behaviours had not always been assessed. For example, on Aynsley unit, we saw one person who used the service physically harm another person on two occasions. The victim of these incidents showed signs of distress and discomfort after each incident. We asked staff how they managed the risks associated with this person's behaviours, but staff told us they were not aware of any risks. This person's care plan contained no risk assessment or management plan to guide staff in how to manage this behaviour. This was despite their care records showing that they had recently been physically aggressive towards staff on at least six occasions. This showed that the risks associated with this person's behaviours that challenged had not been assessed and plans were not in place to guide staff on how to protect people from these risks.

Incident records showed that personal care was not always delivered in a safe manner. For example records

from Aynsley unit showed that six recent incidents had occurred as a result of unsafe support from the staff. These incidents included; skin tears during personal care, cuts to fingers during nail care and trapped or knocked body parts during moving and handling support. All of these incidents were preventable and should not have occurred as people should be supported by staff in a safe manner.

We found that medicines were not managed safely throughout the service. People's medicines were not always available when they needed them as effective ordering systems were not in place. For example, one person's medicines administration records (MAR) showed they had missed two doses of a medicine they needed to help manage their mental health as the stock had ran out. This meant that the person had not received their medicines as prescribed and they were at risk of experiencing symptoms of withdrawal and/or a decline in their mental health as a result of this. We found that medicines were not always stored safely. For example, for a 21 day period, the medicines fridge on Aynsley unit had been running at a temperature that was too high for some of the medicines it contained. No action had been taken in response to this which meant some people's medicines may not have been safe to administer. This included one person's insulin. We also found that medicines were not administered in a safe manner. For example, by looking at three people's inhalers and MAR's, we found that all three people had not received the correct dosage of the inhalers they needed to help them to breathe effectively. One of these people had recently been prescribed an additional medicine for their breathing, but no one had identified that their inhaler was not being administered as prescribed to manage their breathing.

We found inaccuracies in the numbers of stock recorded on people's MAR's and the actual numbers of medicines in stock. For example, on Stafford unit, we could not identify if three people had received the medicines they needed to treat a mental health condition as prescribed because the numbers of medicines in stock did not match the number of medicines recorded on their medicines records. These inaccuracies meant people who used the service could not always be assured that they had received their medicines safely and as prescribed.

We also found that protocols were not in place to guide staff how to safely administer medicines covertly or through a percutaneous endoscopic gastrostomy tubes (PEG). A PEG is a tube that is fitted through a person's abdominal wall into their stomach and is used to administer nutritional and medicine support to people who are unable to eat and drink safely. We asked two nurses how they supported a person with a PEG to take their prescribed medicines. Both nurses gave us different accounts of how they would do this as no agreed protocol was in place. Staff told us and care records showed that pharmacy advice was not always sought when medicines were being administered covertly in food and drink to ensure this was completed in a safe and effective manner. Again, nurses we spoke with gave us different accounts of how they would administer medicines covertly. This meant people were receiving inconsistent care that was potentially unsafe.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider was no longer in breach of this Regulation as some improvements had been made as staffing levels had increased. However, further improvements were still required to ensure effective deployment of staff.

We received mixed feedback from people and their relatives about the staffing numbers and responsiveness

of staff. Comments from people and their relatives included; "I sometimes have to wait a while to go to the loo if they are busy", "They usually come quickly, but sometimes I have to wait" and, "When they are fully staffed it's great, when they are short people have to wait that bit longer". The majority of staff told us that improvements had been made to staffing levels. However, all staff also reported there were times when they felt they were understaffed. Comments from staff included, "We didn't have enough staff before. It's much better now, but sometimes we are still short" and, "Staffing is the biggest let down really. There are times when we are short". Some of the staff rotas we viewed showed gaps in staffing, but unit managers and the home manager told us these gaps were filled by agency staff. We asked the home manger to evidence this, but they were unable to confirm this as this information was not recorded on the rotas. This meant we could not be assured that staffing gaps were consistently filled.

During our inspection, we saw that staffing levels had increased, call bells were answered promptly and staff supported people in an unrushed manner. However, staff were not always deployed effectively to ensure people's needs were met in a safe and consistent manner. For example, on Spode unit, one person's care records stated they needed 30 minute observations by staff to ensure their safety and the safety of other people. On the second day of our inspection, we found these checks had not been completed for a four hour period. Staff told us the checks had not been competed as no one had been allocated this task. This showed that staff had not been effectively deployed to manage this person's risks. On Aynsley unit we also saw that staff were not effectively deployed to consistently promote people's safety. For example, staff did not witness one of the incidents of physical aggression that we observed as they were not observing that part of the communal area. When we fed this back these concerns to the unit manager's, they took action to ensure these immediate staff deployment concerns were addressed. We will check that these actions have been effective at our next inspection.

At our last inspection, we found that people were not protected from the risk of abuse because effective systems were not in place to ensure staff had the skills to recognise and report potential abuse to the local authority's safeguarding team. At this inspection, we found that the provider was no longer in breach of this Regulation as improvements had been made as incidents of alleged abuse were now being identified and reported by staff. However, some further improvements were required to ensure potential abuse was consistently reported in an effective and prompt manner when incidents of alleged abuse occurred outside of standard working hours. For example, incident records showed and local authority staff told us that one incident of alleged abuse was not reported to them until three days after the incident occurred. This meant that incidents of alleged abuse were not always reported in a prompt manner in accordance with national and local safeguarding guidance.

At our last inspection, we found that safe recruitment systems were not in place to ensure people were protected from the risks of receiving care from unsuitable staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had been made. Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. When checks of staffs' criminal history checks came back positive, records showed that risk assessments had been completed to assess and manage any potential risks that any previous criminal history posed to people.

At our last inspection, we found that the risk of infection outbreaks were not being managed effectively. At this inspection, we found improvements had been made to the cleanliness of the environment and equipment. Through conversations with staff we were able to identify that they had the knowledge and skills required to prevent and control infection outbreaks. This meant people were now protected from the risk of avoidable infections.

Requires Improvement

Is the service effective?

Our findings

People told us they could see doctors and other health and social care professionals when they needed to. One person said, "They get the doctor for me if I'm poorly". Care records showed that advice and support was requested from health and social care professionals in a timely manner in response to changes in people's health and wellbeing. However, we found that the advice given by professionals was not always followed by the staff. For example, on Aynsley unit a visiting health care professional had recommended that one person should have a seating assessment if they continued to fall from their chair. This assessment had not been requested or undertaken as recommended despite care records showing that this person had fallen or slipped from their chair on at least eight occasions since the professional had visited. The unit manager confirmed that this assessment had not been requested or completed. They told us they were waiting for the person to be reviewed for increased funding. However, this should not have delayed this specific assessment from being requested. This meant that the advice of the health care professional had not been followed and the person had fallen on multiple occasions as a result of this.

A visiting healthcare professional on Aynsley unit also told us that professional advice was not always followed in a timely manner. They shared a recent example where a person on Aynsley unit required specific nursing interventions to be completed to help to protect their skin from damage. When they visited the person again, the interventions had not been completed as requested. They said this had placed the person at risk of their skin deteriorating. Care records we viewed confirmed that the recommended interventions had not been completed in a timely manner as requested. This meant the staff did not act on professional advice promptly as requested and the person had been placed at risk of harm.

The above evidence shows that professional advice was not always acted upon to promote people's health, safety and wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about the food at Stadium Court. Comments from people included; "The food is nice", "It's [the food] not bad at all" and, "It's [the food] not very exciting". People who could eat a 'regular diet' and their relatives told us that their food preferences were mostly met. One person said, "They ask me what I fancy" and they confirmed they received meals that were in line with their preferences. Another person's relative told us that the person they visited didn't like the standard breakfast choices offered, so staff prepared them bananas on toast which was a breakfast meal that they enjoyed. However, we saw that people who required 'specialist diets' such as pureed or other modified meals were not offered the same level of choice. For example, on both days of our inspection, we saw that on Aynsley unit everyone who required a modified diet was served the same pureed meal at lunch time and no choice was offered to them. Staff confirmed that people who required modified diets were not offered the same level of choice as people who required regular diets. One staff member said, "The kitchen don't send out a cold choice for people on pureed diets at tea time, so they have to have a hot meal". There was no evidence to show that people had lost weight as a result of this.

We saw that people did not always get the modified diet that they had been prescribed by health care

professionals. For example, on Aynsley unit, we saw that one person's care records showed they required a pre mash diet. However, we saw that they were served pureed meals on both days of our inspection. Two of the three staff we spoke with about this person's dietary needs were not aware that they required a pre mash diet. This showed that staff did not always know how to support people correctly with their dietary needs. There was no evidence to show that this person had lost weight as a result of this.

People and their relatives told us that staff monitored weights and took action in response to changes in weight. One relative said, "[Person who used the service] was weighed weekly as they had lost a lot of weight while they were in hospital. They have now regained most of their weight and it's levelling out now". Care records showed that people's weights were monitored and advice was sought from doctors and dieticians in response to changes in weight. However, improvements were needed to ensure the provider could evidence that dietary supplements had been administered as prescribed. These supplements were mostly given to people by the care staff, but nursing staff told us they signed people's medicines records to show they had been given when they did not know if this was the case or not. This meant there was a risk that people may not have received their nutritional supplements as prescribed as effective recording systems were not in place to evidence this. There was no evidence to show that people had lost weight as a result of these ineffective systems.

Staff told us they had received training to enable them to support people who used the service. We saw that when training had been delivered it had been effective. For example, staff told us they had received training so they knew how to support people to move safely. One staff member said, "Moving and handling training was beneficial as I know how to move people safely". We saw people were supported to move in a safe manner on all the units which showed this training had been effective. However, we identified significant gaps in staff training that placed people at risk of receiving poor, unsafe care. For example, the training records we viewed showed that only two thirds of the staff responsible for medicines administration had received the training the provider stated they required to enable them to administer medicines safely and effectively. This may have contributed to the unsafe medicines practice that we observed. Staff told us and training records also showed significant gaps in end of life care training which placed people at risk of receiving poor end of life care. The home manager told us that plans were in place to address some of the training gaps, but these gaps needed to be prioritised to address risk.

People who could tell us about their care told us their consent was sought before staff offered assistance. We saw that this was the case as staff asked people if it was okay to support them before they provided any support. For example, we saw staff ask people if they agreed to be supported to access the toilet before they provided this support

Some people who used the service were unable to make certain decisions about their care. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff demonstrated they understood the principles of the MCA by telling us about how the Act applied to the people who used the service. Care records showed that the requirements of the Act were followed when people were unable to make important decisions about their care. For example, one person who was at high risk of falling had been assessed as not having the ability to consent to the use specialist equipment to help reduce their risk of injury if they were to fall from their bed. Their care records showed that the decision to use this specialist equipment had been made in their best interests in consultation with health care

professionals and relatives.

People told us and we saw that they could move freely around their unit if they were safe and able to do so. However, some people who used the service had some restrictions placed upon them to keep them safe and well. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that where restrictions had been placed upon people, applications under the DoLS had been made and authorised which meant people were being lawfully restricted in their best interests. We also found that staff had an understanding of how to support people in line with their DoLS.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we saw that people's dignity was not always promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider was no longer in breach of this Regulation as some improvements had been made. For example, we saw that people were supported with their continence needs in a timely manner and we saw that staff ensured peoples clothing covered their body when they were being supported to move using the hoist. However, further improvements were still required to ensure people's dignity was consistently promoted as people and their relatives shared with us and we saw some examples of undignified care. For example, a relative of one person who used the service told us that on occasions they had found their relative wearing other people's clothing. They confirmed this person required support to dress and always had access to clean items of their own clothing. They said that the person they visited had always taken pride in their appearance and it would cause them distress if they knew they were wearing other people's clothing. On Stafford unit, we also observed some staff members discussing the care needs of other individuals whilst they supported people. This meant people's dignity was not always promoted by the staff.

We saw that some people were not supported to make choices about their care. Some people who used the service struggled to understand information and/or express their needs due to medical conditions, such as dementia. Staff did not use alternative communication methods to help these people be involved in making choices about their care. For example, at mealtimes, people were not shown a picture or an example of the choices that were available to them. The home manager told us that pictorial meal cards were available, but we did not see these being used during our inspection. This meant staff did not enable people to make choices about their care and there was a risk that people would not receive their care in line with their personal preferences.

Some people told us that some of the staff knew their likes, dislikes and care preferences well. For example, one person told us that a member of care staff understood their sense of humour and made them laugh. They said, "This one [a member of care staff on Aynsley unit] makes us laugh with old folks off the TV". We observed this staff member engage with this person by doing impressions of TV characters. The person guessed the characters and showed they enjoyed the interaction by laughing. We saw that some people were supported by staff who knew their needs well. This was evident through some of the interactions we witnessed between people and staff. For example, we saw one staff member reassure a person who was displaying signs of agitation by talking to them about their husband. The staff member said, "She likes talking about her husband, it always seems to calm her". However, we found that there was a risk that people would not consistently be supported by staff in this positive manner because care records did not always contain the level of detail needed to provide positive, person centred care. For example, the care records of the person who we saw respond positively to staff when they spoke with them about their husband, did not record that this was a conversation topic to use when they displayed signs of agitation. This meant that any temporary or new staff at the home would not have access to the information needed to form effective, caring relationships with people who used the service.

The majority of people and relatives we spoke with spoke positively about the staff. Comments included; "They are so kind, they look after me well", "They look after me ever so nice and they show respect" and, "I can't believe how well [person who use the service] is looked after, and how they are with me. The kindness of the staff is lovely to see. They don't just do it because I'm there; I hear them being kind when I'm round the corner too". However, some people and their relatives expressed concerns that staff didn't always have the time needed to have quality, caring interactions. For example, one person said, "The staff are generally alright, but they don't have time to park their bottoms for five minutes". A relative of a person who used the service said, "I don't think they always have enough time to do caring, it's hard to do everything, it takes more time to stop and talk". This meant that although the majority of people felt the staff were kind, some people felt they didn't always have the time to consistently have quality, caring interactions with them. Staff told us and we saw that they spent significant periods of time writing in people's care records. We saw that this recording was completed away from people who used the service rather than engaging with people during this task. This confirmed that some staff members did not use their time effectively to engage and interact with people.

At the time of our inspection, a small number of people were in receipt of end of life care. Feedback from the family of one person who was in receipt of this care was very positive. They told us they had been offered open visiting and they were enabled to stay at the service with the person who was in receipt of this care. They also told us that a member of staff who had moved to work on another unit at the service often 'popped in' after their shift to check how they were doing, which showed they genuinely cared for the person.

Although there were significant gaps in end of life care training, we saw that staff knew how to request specialist support from end of life care nurses who worked at the local hospice. This enabled people to access the equipment and medicines that they needed to experience pain free and dignified end of life care.

We saw that where required, people had end of life care plans in place that outlined their preferences, such as their preferred place of death. Anticipatory medicines were requested when a person was identified as nearing the end of their life. Anticipatory medicines are used to manage people's symptoms during their end of life. These medicines help people to experience a pain free and dignified death. The provision of anticipatory drugs ensured that medicines and pain relief were available to people at the right time to enable them to receive their end of life care in their preferred place.

We saw that people's privacy was promoted. People who were able to choose to spend time alone in their bedrooms were supported to do so and we saw that people were supported to access private areas of the service for appointments with health and social care professionals. Private areas were also available for use if people chose to use them for visits from relatives and friends.

Requires Improvement

Is the service responsive?

Our findings

Some people and their relatives told us that care was not always delivered in accordance with people's individual preferences. For example, one relative said the person they visited required specific toiletries to be used in order to prevent skin reactions. They told us that there were occasions when the person they visited suffered from a rash as a result of not using their specified toiletries. They said that they had found other toiletries in their relative's room on a number of occasions despite the person's own toiletries being available. Some of the complaints records we viewed also showed that people's care preferences were not always met. For example, one person had complained because they were not supported to have a shower at their preferred time. This was because the staffing numbers on their unit were too low to accommodate this at the time.

We found that detailed plans were not always in place for the staff to follow to ensure people's care needs and preferences were consistently met. For example, on Aynsley unit a person's care records showed and we saw that they could display behaviours that challenged in the form of aggression. This person's care plan stated that staff needed to provide this person with 'reassurance' when they displayed this behaviour. However, the care records didn't state how this reassurance should be given. We asked staff how they reassured the person and we were given different answers. For example, one staff member told us they would talk to the person about their family, but another staff member said they would offer the person a drink rather than engage in conversation. This meant staff used different approaches when they responded to this person's behaviours as a detailed plan was not in place. On Stafford unit we saw and heard one person in their bedroom making a tapping noise for 26 minutes. We saw that their call bell was not in reach. The person told us, "I want to go to the toilet". We saw a staff member walk past this person's room, but they did not enter the room or interact with the person despite the on-going tapping noise. We asked staff how they responded to this person's tapping. Staff told us this was a behaviour that the person regularly displayed, but they gave us different accounts of how they would respond to this behaviour. The person's care records did not record the tapping as behaviour and no plan was in place to inform staff about what this behaviour meant and how to respond to it. This meant staff did not always have access to the information needed to provide people with consistent care that met their individual needs and preferences.

Care plans contained some evidence of the involvement of people and their relatives in the planning of their care as information about people's likes, dislikes and life histories was recorded. However, most people and their relatives told us they were not involved in the review of their care needs or the care needs of their loved ones. One relative said, "They don't always tell me when [person who used the service] is unwell. They had a water infection that made them agitated, but I didn't know this was the cause of their agitation at the time". This had made the relative feel unduly concerned about the change in their loved one's presentation. Another relative told us they had requested a review of their loved one's needs as they had significant concerns about their safety. They told us they felt that their views about their loved one's safety were not being listened to or acted upon. Staff and care records confirmed that this was the case as the relatives request for a review had not been acted upon. When we fed this back to the home manager they told us they would request an immediate review of this person's needs as requested by the relative. During our

inspection, we observed nursing staff on Aynsley and Stafford complete care reviews in the nursing office without involving the person and/or their relatives. This confirmed that people and their relatives were not consistently involved in the review process.

People and their relatives told us and we saw that some improvements had been made to the way that people were supported to participate in leisure and social based activities that were important to them. Comments from people and their relatives included; "I join in the activities if I feel like", "The activities are good and I always see [person who used the service] doing something" and "I've seen musical activities and a singer has visited. They also had a party on Good Friday". The numbers of activity coordinators had increased and we saw that people were supported to engage in activities that were meaningful to them on a one to one and group basis. However, further improvements were required to ensure people could access outdoor spaces and the local community when they wished to do so. For example, we saw one person on Aynsley unit repeatedly ask to go outside, but this was not facilitated by the staff as they were busy with other tasks.

People and their relatives told us they knew how to complain about the care. One person said, "I'd tell the staff if I wasn't happy with anything". A relative told us about a complaint they had raised with the home manager. They told us the complaint had been dealt with to a satisfactory standard and they, "Would not hesitate to complain again if necessary". We saw that complaints were recorded, investigated and acted upon appropriately and in line with the provider's complaints procedure. This procedure was clearly displayed on all units at the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that effective systems were not in place to assess monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the changes the provider had not been effective in making and sustaining the required improvements. As a result, people continued to receive or be at risk of receiving unsafe and/or poor quality care.

Effective systems were still not in place to ensure risks to people's health, safety and wellbeing were consistently assessed, recorded, planned for and managed. For example, one person's care records showed they had recently fallen or placed themselves on the floor on at least five occasions. No care plan was in place to help staff manage this person's falls risk and behaviour. Staff we spoke with were aware of this person's falls risk, but they gave us inconsistent answers about how this risk should be managed. This meant this person's falls risk had not been specifically planned for and staff were managing this risk inconsistently and ineffectively as the person continued to fall/place themselves on the floor.

Another person's care records stated that they had displayed no incidents of aggression, but that any incidents of aggression should be recorded on a behaviour monitoring chart. This person's daily records showed they had recently been aggressive to staff on at least six occasions. None of these incidents had been recorded on a behaviour monitoring sheet as planned. During our inspection, we saw that this person's behaviours had escalated as we saw them become physically aggressive towards another person who used the service on two occasions. This meant the increased risks associated with this person's behaviours had not been assessed and planned for as the pattern of increased aggression had not been identified and acted upon by the management team. This showed that the systems in place to check the information in people's care records were not yet effective in identifying that people's care plans were not always being followed as planned.

We found that although the provider's pressure ulcer and wound management policy was based upon national best practice guidance, effective systems were not in place to ensure this policy was consistently followed to promote people's safety and wellbeing. For example, in line with The National Institute for Health and Care Excellence (NICE) Pressure ulcers: prevention and management guidance, the provider's policy stated that photographs of wounds were required. Care records showed that photographs had not been taken for two of the four people whose care records we viewed. The reasons for the lack of photographs were recorded as, 'Unable to photograph as camera not on unit' and, 'No photos as camera not working'. The lack of photos had not been identified or followed up by staff or the provider to ensure that their own policy was followed. This meant effective systems were not in place to enable staff to effectively monitor people's wounds in accordance with the provider's policy. We also found examples of the inaccurate assessment and recording of people's risk of pressure ulcers. For example, one person's records showed that their risk of pressure ulcers had been calculated incorrectly for a six month period. This meant staff had not correctly identified when this person became at 'very high' risk of pressure ulcers, therefore a suitable care plan to manage this very high risk had not been put into place in a timely manner to help manage this risk.

Effective systems were not in place to ensure prompt action was consistently taken following incidents to prevent the risk of future harm and/or injury. Incident records on Aynsley unit showed two people had sustained cuts to their fingers whilst having their nails cut by staff. One of these incident forms stated the action required was to, 'investigate how this could have happened'. However, no investigation had been recorded. The second incident form stated, 'New equipment to be looked into to decrease risk of fingers being cut'. We therefore asked staff on the unit to show us the equipment they used for cutting people's nails. Staff told us they bought their own nail clippers in for use on the unit. One staff member said, "It would be good if there were some on the unit". Staff on Stafford unit also told us they bought their own nail clippers in from home as none were available. When we fed this back to the home manager and provider, they told us nail clippers had been purchased and staff could ask for them from the management team. This showed that although the new equipment had been purchased, staff did not know it was available, so people continued to be at risk of injury during the cutting of nails.

We saw that incidents that had been reported were analysed for themes and trends. However, effective systems were not in place to ensure that safety incidents were reported effectively to enable the home manager and provider to complete accurate incident analysis. For example, earlier in the year, one person had received one to one support from staff to help manage their risk of falling. This one to one support had later been stopped as the number of falls the person suffered had significantly decreased. This person's care records showed that they had been found on the floor on at least 10 occasions in the 31 days since their one to support had stopped. However, only five of the 10 falls had been recorded on incident forms which meant the home manager was not aware of the additional five falls that had not been reported. This inconsistent and inaccurate recording of this person's safety incidents had not been identified by the home manager or provider which showed that care record audit systems and incident reporting systems were not effective.

The systems in place to ensure medicines were managed safely were not effective. For example, the provider had introduced a post medicines rounds review which was completed by staff after every medicines round (four times a day). One of the questions staff had to answer during this check was, 'Are there enough medicines available for the next 48 hours?' We looked at the post medicines round review records for Wade unit as we were aware that one person had not received two doses of a medicine they needed for their mental health. The review records for the 48 hours before this medicine became out of stock showed that this person's medicines were available. This meant this medicines check was not effective. Medicines audits also hadn't identified that detailed protocols were not always in place to ensure people received their medicines safely and consistently when they were administered covertly or through PEG's. For example, nursing staff gave us different accounts of how they would administer medicines to one person with a PEG which meant that person had received inconsistent and potentially unsafe care.

Nutrition and catering audits had not identified that people were not always getting a choice of meals and/or their prescribed diet. For example, a nutrition and catering audit completed on Aynsley unit in March recorded that people were getting soft, fork mash and pureed diets when required. However, we saw and care records showed that one person had regularly not received their prescribed diet. After speaking with staff, we identified that this was because the catering ordering forms they used were not correctly designed to ensure people received their prescribed diet. This was because only two modified diet categories were listed on the ordering form, rather than the four nationally recognised modified diet categories. This had also not been identified through the completed nutrition and catering audits which showed they had not been effective in identifying some of the concerns with nutrition and catering we had identified.

The home manager told us about the changes that had been to the management structure at the service. This included an increase in unit manager's supernumerary hours, which meant unit managers now had more management time allocated to them. Unit manager's confirmed this. One unit manager said, "My

supernumerary hours have gone up to 24 now, the workloads gone up as a result, but it means we are doing more audits now". Deputy managers were also being recruited to support the unit managers with the day to day management of the units. Despite these positive changes in the way the units were managed, we found that staff continued to not always be deployed effectively to ensure people's safety. For example, staff were not always effectively deployed to observe people who were at a very high risk of falling and one person's 30 minute checks had not been consistently completed during our inspection as this task had not been allocated to a staff member. This showed that effective systems were not yet in place to ensure effective staff deployment and people were at risk of harm as a result of this.

The home manager and provider had a detailed action plan in place that set out the improvements they needed to make. We found that progress was being made against all the actions listed on the plan. However, the provider's audit systems were not yet fully effective in identifying further areas for improvement. For example, the concerns we identified around the provision of modified diets had not been identified as an area of concern that needed adding to the action plan. This meant further improvements were required to ensure audit systems were effective in identifying areas of concern/improvement.

The above evidence shows effective systems were not in place to assess monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the provider had failed to notify us of some incidents of alleged abuse as required under their registration with us. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found that all reportable incidents were now being reported to us as required; therefore the provider was no longer in breach of this Regulation. However, improvements were still needed to ensure the correct notification documents were consistently used to do this.

People and their relatives told us they had noted improvement in the quality of the care. Comments included, "Overall, things are a lot better" and, "Things are improving". A relative also told us that they had been informed of the outcome of our previous inspection and had been kept up to date with the provider's improvement plans. They said, "We've had meetings with the home manager, I've attended them all". Staff also told us improvements had been made. Comments from staff included, "The standards did drop, but they are much better now" and, "Things have really improved, there is good teamwork and the manager is supportive". Staff also told us the outcome of the last inspection had been discussed with them so that they could be involved in making the required improvements. One staff member said, "The last inspection was discussed with staff, we were all made aware of the areas of concern and the action plan was shared with us".

Staff told us they received regular supervision from senior staff to assess and monitor their performance and development needs. Comments from staff included, "We talk about any issues that need to be addressed" and, "We talk about any training I need to do and how I can improve in my job". Through our observations and discussions with staff we found that there had been a significant change in the staff culture at the service. Staff were aware that there had been shortfalls in the care and were committed to make the required improvements.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Effective systems were not in place to ensure people consistently received their care in a safe manner. Professional advice was not always acted upon to promote people's health, safety and wellbeing.

The enforcement action we took:

We served the provider with a warning notice telling them to make the required improvements by 31 July 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Effective systems were not in place to assess monitor and improve quality and manage risks to people's health and wellbeing.

The enforcement action we took:

We served the provider with a warning notice telling them to make the required improvements by 31 July 2017.