Aps Care Ltd

Stradbroke Court

Inspection report

Green Drive
Lowestoft
Suffolk
NR33 7JS

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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?	**Requires Improvement**

Summary of findings

Overall summary

Stradbroke Court is a residential care home for up to 43 people. The service provides care and support to people with a range of needs which include; people living with dementia and those who have a physical disability. There were 37 people living in the service when we inspected on 8 December 2016. This was an unannounced inspection.

The registered manager was no longer in post but an application to cancel their manager's registration to CQC had not been received. Following our inspection we received confirmation the provider had submitted an application to CQC to cancel the registered manager's registration. 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. A new manager had been appointed by the provider to run the service and was in the process of registering with the CQC.

The provider has been registered for Stradbroke Court since 4 September 2015. During this time there have been significant management changes and prior to this inspection we received a high level of concerns relating to the safety and quality of the service from different stakeholders.

Where appropriate we made safeguarding referrals or asked the provider to investigate and report back their findings In addition we chaired a multi-agency meeting with the provider's nominated individual and the manager to discuss information of concern received about the service from a number of stakeholders. These included insufficient staffing levels, ineffective leadership and governance arrangements, unsafe medicines management and poor moving and handling practices. In addition we were made aware of serious shortfalls regarding Legionella arrangements and health and safety procedures within the service, following a visit from the food/environment safety team. At the meeting the manager shared with us their development plan for addressing the shortfalls and improving the service. We decided to inspect the service to ensure risk was being mitigated and people were safe living in the service.

During the inspection we found there were shortfalls and inconsistencies across the service which impacted on the quality of care provided. Where breaches were identified you can see what actions we have told the provider to take at the end of this report.

Infection control measures were not robust. We observed maintenance contractors carrying disconnected sluice fittings past and over people eating their lunch time meal. The care staff were not alert to the risk of infection and did not challenge or re-direct the workmen. In addition the cistern of a toilet in one of the communal bathrooms was not secure presenting a risk of infection.

There was a task led culture in the service resulting in a lack of cohesion and team work amongst staff. Improvements were required in the deployment and organisation of staff to meet people's needs safely and effectively.

Improvements were needed to people's care records. We were not assured that information was accurate, reflected people's needs and their preferences.

Although staff routinely gained consent before providing care, people's care plans did not demonstrate a clear understanding of the Mental Capacity Act (MCA) and assessment process.

The atmosphere within the service was not calm. Internal door alarms, call bells and staff communicating to each other via internal radio's created an unsettling and disruptive environment, making it difficult for staff to hear people calling out. However we observed that call bells and requests for assistance were responded to in a timely manner.

The environment of the service required attention. Internal paintwork within the four units was peeling and chipping and the communal carpets were sticky and stained. There was a discarded toilet in the courtyard which was undignified and disrespectful.

Overall people were provided with their medicines when they needed them and in a safe manner. However additional work was needed to embed best practice, for example we had to prompt staff to reduce the room temperature to ensure people's medicines were stored at an appropriate temperature

Staff were not consistently supported to develop their skills within their role. An effective system was not in place to assess staff competency and performance. Supervision of staff was not carried out consistently.

Whilst we observed positive communication throughout the day between staff and people the majority of conversation was task focused. There was little incidental or social conversation from staff to engage and interact with people. Further work was required to ensure all staff were consistently caring in their approach, promoted people's independence and used language that valued people.

People were not supported to live full, active lives and to engage in meaningful activity within the service. The activities coordinator was enthusiastic but working in isolation. We observed that at times people were socially isolated and disengaged from their surroundings. Improvements were needed to ensure people were provided with stimulating activities appropriate to their needs.

People told us that they felt safe. Staff knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support. People's privacy and dignity was promoted and respected.

The service was in a transitional period with a new manager in post. Although we found several inconsistencies within the service, progress had been made by the manager to address the immediate risks to people from unsafe medicines management and poor Legionella arrangements. In addition previous staff vacancies had been recruited to and changes to the management structure were being implemented.

The manager was working hard to address the shortfalls within the service. They were in the early stages of implementing a development plan to address concerns and to drive continuous improvement. The manager was open and responsive to issues we raised and acted immediately to make positive changes as a result.

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.

Infection control measures were not robust and improvements were needed with the environment of the service.

Improvements were required in the deployment and organisation of staff to meet people's needs safely and effectively.

Systems in place to keep people safe such as incident reports and people's risk assessments were not robust.

Procedures were in place to safeguard people from the potential risk of abuse.

Overall people were provided with their medicines when they needed them and in a safe manner. However further work was needed to embed safe management of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff sought people's consent before providing care and support. However, people's care plans did not demonstrate a clear understanding of the Mental Capacity Act (MCA) and assessment process.

Improvements were needed to ensure staff were effectively trained, supervised and supported in their role to meet people's needs.

People's fluid intake was not always monitored effectively.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Further work was required to ensure staff were consistently caring in their approach, promoted people's independence and used language that valued people.

People's privacy and dignity was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's wellbeing and social inclusion was not planned and delivered to ensure their social and emotional needs were being met.

Care plans required further development and improvement to ensure they were accurate, met people's needs and reflected their preferences.

The complaints process was not robust.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We found a task led culture amongst the staff with no clear lines of leadership and accountability during the shift.

The manager was addressing the shortfalls within the service through a development plan. This needs to be implemented, embedded into the service provided and sustained over time to ensure people received a good quality service.

Stradbroke 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.

This unannounced inspection took place 8 December 2016. The inspection team consisted of an inspector, a specialist advisor who had knowledge and experience in nursing and dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

Due to concerns reported about the service we chaired a multi-agency meeting with relevant stakeholders, the manager and the provider's nominated individual to discuss what measures were in place to provide people with safe and effective care.

During the inspection we spoke with twelve people who used the service and eight people's relatives/visitors. We observed the interaction between people who used the service and the staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We spoke with the manager, deputy manager, eight members of staff including care and domestic staff and two visiting health professionals. In addition we received feedback from four health and social care professionals.

To help us assess how people's care needs were being met we reviewed five people's care records. We also looked at records relating to the management of the service, recruitment, training, and systems for

monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We found shortfalls within the service in keeping people safe. Infection control measures were not robust. We observed maintenance contractors carrying disconnected sluice fittings past and over people eating their lunch time meal. The care staff were not aware and alert to the risk of cross infection and did not challenge or re-direct the contractors. In addition the cistern of a toilet in one of the communal bathrooms was not secure presenting a risk of potential contamination/ cross infection.

Reviews of risk assessments were not robust. People's records were not always updated when their needs had changed. For example one person who was receiving end of life care and was being care for in bed full time had a fire evacuation plan that stated they could walk from the building. Further work was needed to ensure that people's records were accurate, reflected their needs to ensure staff cared for them safely and consistently.

Incident reporting was ineffective. Improvements were needed to ensure incident reports reflected the specific strategies in place to reduce harm and reoccurrence. Phrases such as 'monitor the resident' and 'use sensor mats' did not provide staff with sufficient guidance about how to deliver ongoing safe care for people identified at risk. Incident records did not effectively show the care given to people at the time of incidents, for example there was no information of how distress was managed or harm was assessed. Incident reports were inconsistent in reflecting if family members had been informed. Where a person had been taken to hospital following an incident there was no follow up record to say whether they were admitted or what injuries were sustained. This made it difficult to track incidents and their outcomes in order to provide learning and development opportunities for the staff and improvements to the service.

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act.

Staffing levels were not needs led or person centred at all times. Staff were visible and generally responsive to calls to assist people. However there was no overall leadership on the four different units and it was not clear what individual staff members' roles were or who was in charge. Improvements were needed to ensure the deployment and organisation of staff during the shift was effective. We found a lack of cohesion and team work amongst the staff resulting in a task led culture due to ineffective leadership and structure during the shift.

It was difficult for us to determine members of staff as not all staff wore name badges or uniforms to identify themselves. A notice board in a communal area depicting which staff were on duty was incorrect and had not been updated to reflect staff changes due to sickness. In addition the staffing rotas were incomplete. They did not provide sufficient information to ensure the shift was effectively covered to meet people's needs. The existing form reflected staff names but did not determine if they were based on a particular unit, floating between units or leading the shift. Staff roles and responsibilities for the shift were not clear.

People and relatives told us that staff responded fairly quickly to call bells and usually within five minutes. One person told us, "It varies, sometimes it's very quick, and sometimes you have to wait. It depends who is

on [which staff were working]." Another person commented, "Sometimes they [staff] come and sometimes you have to wait maybe more than five minutes; not been a problem, I know they always come." When staff were not able to assist people they answered the call bell to explain they would be with them as soon as they were able.

Staff told us there were insufficient numbers of staff across the service to safely meet people's needs. One member of staff said, "[Name of person] is challenging; there was only me on there [name of unit] this morning and [names of two people] wander and go off into the garden. I do feel supported but sometimes feel I am not listened to. You get put to different places all the time; today was the worst time." Another member of staff said, "The radios are used to alert the team leaders or floating staff you need help. Can take a while for [staff] to come and help; not everyone is patient and understanding why they have to wait." A third member of staff commented, "You are very isolated on [name of unit]. I hate it down there; door alarms keep going off and they [staff] radio that your door alarm is going off but if you are helping someone you cannot leave them. Since September we work all over the place, you have residents moving around, those with dementia it is dangerous; when you stay on a unit you know your own residents and what to look out for."

Staff handover records seen from the day to night staff read, 'get as many [people up] in the morning do [name of two of units] meds [medicines] as short staffed due to meds training'. This was an example of not focussing on the wellbeing or daily experience of people. It also placed unnecessary pressure on night staff at the end of a twelve hour shift by giving them extra responsibility. It would have been more effective to plan medicines training for staff at a more appropriate time.

We discussed the staffing shortfalls with the manager who confirmed the uniforms and name badges were on order. They demonstrated how the staffing levels were determined by the needs of the people and this was regularly assessed. They advised us that as part of ongoing improvements to the service the staff rotas were due to change and showed us the new template which addressed our concerns of how the shifts were organised. They also told us the notice board containing staffing information was being updated to include the names and pictures of the staff members on shift, which unit they were working and who was in charge. This would help people to recognise staff and know who they could speak to if they had any issues to raise.

Improvements were needed to staffing arrangements to ensure sufficient numbers of staff are effectively deployed to safely and effectively meet people's needs.

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

The atmosphere within the service was not calm. Internal door alarms, call bells and staff communicating to each other on the radio created an unsettling and disruptive environment, making it difficult for staff to hear people calling out. The manager advised us that quotes had been obtained to turn off the internal door alarms for the two units affected. They explained that this was not a straightforward process and specialists had been contacted.

We were made aware of serious shortfalls regarding Legionella arrangements and health and safety procedures within the service, following a recent visit from the local authority's food and safety office. The service responded with a new legionella risk assessment, policy and procedures. These included arrangements for the removal of dead legs in the water systems and implementing water monitoring and flushing regimes to protect people from the potential risks.

The environment of the service required attention. Internal paintwork within the four units was peeling and chipping and the communal carpets were sticky and stained. There was a discarded toilet in the courtyard which was not in keeping with providing people with a safe place to live and positive outlook.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People's care records included risk assessments which identified how the risks in their care and support were minimised. This included risk assessments associated with mobilising, falls, skin integrity and behaviours. People who were vulnerable as a result of specific medical conditions such as diabetes had plans in place guiding staff as to the appropriate actions to take to safeguard the person concerned. This also included examples of where healthcare professionals had been involved in the development and review of care arrangements.

Overall people were provided with their medicines when they needed them and in a safe manner. Arrangements for the storage and disposal of medicines were appropriate. Staff liaised regularly with district nurses for advice regarding medicines including anticipatory end of life drugs. Stocks of controlled drugs tallied with the record. Staff washed their hands before administering medicines and sought consent from people; carefully observing nonverbal communication. We were aware that the reporting of drug errors and incidents had not been effective in the past and the service was working with external healthcare professionals from the 'Clinical Commissioning Group (CCG) to mitigate this risk. This included implementing a new system and additional staff training on medicines administration.

However improvements were needed to embed best practice regarding safe medicines management. We had to prompt staff to reduce the room temperature to ensure medicines were stored at an appropriate temperature. Information held with the medicine administration record (MAR) chart could be further developed to include how people preferred to take their medicines, for example on a spoon, with juice. An updated medicines policy to include the use of covert and medicines prescribed to be administered as required (PRN) was being developed by the manager as well as the undertaking of medicines audits as part of the ongoing development of the service.

People told us they felt safe and protected living in the service. One person said, "I feel fine here, yes I am very safe here." Two people smiled and nodded when asked if they felt safe living in the service.

Systems were in place to reduce the risk of harm and potential abuse. The majority of staff had received up to date safeguarding training and those who required it knew of their impending date. They were aware of the provider's safeguarding adults and whistleblowing (reporting concerns of poor practice) procedures and their responsibilities to ensure that people were protected from abuse. Staff knew how to recognise and report any suspicions of abuse to the appropriate professionals who were responsible for investigating concerns. Records showed that concerns were reported appropriately and steps taken to prevent similar issues happening. This included providing extra support such as additional training to staff when learning needs had been identified or following the provider's disciplinary procedures.

Staff employed at the service told us they had relevant pre-employment checks before they commenced work to check their suitability to work with people and had completed an induction programme once in post. This included reading information about people living in the service to ensure staff members could support people safely. Records we looked at confirmed this.

Risks to people injuring themselves or others were limited because equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was guidance in the service to

tell people, visitors and staff how they should evacuate the building if this was necessary.

Requires Improvement

Is the service effective?

Our findings

People fed back that staff were well trained and competent in meeting their needs. One person said, "They [staff] are very kind and supportive; well trained and know what they are doing." Another person smiled, nodded their head and gave us the thumbs up sign to indicate the staff were skilled and capable of meeting their needs. We saw that staff training was effective in meeting people's needs. For example staff communicated well with people in line with their individual needs. This included maintaining eye contact, providing reassurance and using familiar words that people understood.

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were regularly supervised and supported to improve their practice. Discussions with staff and records showed that staff were provided with the mandatory training that they needed to meet people's requirements and preferences effectively, including regular updates. Training was linked to the specific needs of people. For example, diabetes, falls awareness, pressure care awareness, end of life and epilepsy. This provided staff with the knowledge and skills to understand and meet the needs of the people they supported and cared for.

Feedback from staff about their experience of working for the service and the support arrangements in place were positive. They described how they felt supported in their role through regular one to one supervision and team meetings. One member of staff said, "We have regular team meetings, supervisions. The training here is good; mix of face to face and work books. The office is always open if you need to speak to the manager." Another member of staff described the support available, "I have regular supervisions where I can raise things or with the seniors on shift but not a problem to go to management if you need to."

The registered manager described how staff were encouraged to professionally develop and were supported with their career progression. This included new staff being put forward to obtain their care certificate. This is a nationally recognised induction programme for new staff in the health and social care industry. These measures showed that training systems reflected best practice and supported staff with their continued learning and development. A member of staff acknowledged their need to have further training on people's health conditions such as epilepsy but told us they were well supported by senior staff. Another member of staff commented, "I have had all my training and am due refresher updates soon."

Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS were in place where required for people and the appropriate referrals had been made to ensure people were not unlawfully deprived of their liberty.

The management team and staff we spoke with demonstrated how they involved people that used the service as fully as possible in decisions about their care and support. They had a good understanding of the MCA and what this meant in the ways they cared for people. Records confirmed that staff had received this training. Guidance on best interest decisions in line with MCA was available to staff in the office.

People were asked for their consent before staff supported them with their care needs, for example, to mobilise or assisting them with personal care. Care records identified people's capacity to make decisions and reflected they had consented to their planned care and terms and conditions of using the service. Where people had refused care or support, this was recorded in their daily care records, including information about what action was taken as a result. For example, a member of staff told us how they had noticed a change in one person's condition and their reluctance to allow staff to provide personal care. They had respected this but were concerned and reported this to the management team to make them aware of the situation. This action triggered a care review with the person, their family and relevant healthcare professionals to ensure there were no underlying health concerns and to explore how staff could best support the person to ensure their safety and wellbeing.

Feedback about the food in the service was positive and people were particularly complimentary about the cook saying, "[Name of cook] is marvellous." People were seen throughout the day to make choices about what they ate through direct consultation with the cook. One person said, "The food is brilliant. You can have whatever you want. [Cook] is extremely accommodating; nothing to much trouble and usually very tasty." Three people nodded their agreement at this comment and one person said, "I have certain dietary requirements. [Cook] goes out of their way to ensure I have a variety of tasty healthy home cooked meals. They often come in and say, how about this or this. I prefer savoury meals rather than sweet and have been impressed with what has been produced for me. We have been discussing what's on the menu for Christmas today and what I might have." We spoke to the cook who told us they prepare a weekly menu but were able to accommodate changes and people's choices. They were knowledgeable about people's dietary requirements and how to accommodate this in line with their preferences.

The support people received with their meals varied depending on their individual circumstances. Two people told us that they did not make any food for themselves but this was their choice as there were facilities upstairs in the service to enable people to do this. Where people required assistance, they were supported to eat and drink enough and maintain a balanced diet. Staff encouraged people to be independent and made sure those who required support and assistance to eat their meal or to have a drink, were helped sensitively and respectfully. People's records showed that, where required, people were supported to reduce the risks of them not eating or drinking enough. Where concerns were identified action had been taken, for example informing relatives or making referrals to health professionals.

Staff monitored people's health and well-being to ensure they maintained good health and identified any problems. Where staff had noted concerns about people's health, such as weight loss, or general deterioration in their health, they had taken action to reduce the risk. This included prompt referrals to health care professionals and requests for advice and guidance. This showed us that action was taken to maintain people's health and wellbeing. People's care records contained health action plans where required and records of hospital and other health care appointments. Staff prompted and supported people to attend their appointments. A member of staff explained that as people were ageing in the service health appointments were increasing. They described to us how they would be briefed prior to the appointment if they were escorting the person to attend and be expected to feedback when they returned and to document any outcomes or actions arising within the person's care records. These measures ensured that everyone involved in the person's care were aware of the professional guidance and advice given, so it could be followed to meet people's needs in a consistent manner.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person said about the staff approach, "They are kind and really good." Another person commented, "I cannot say anybody is not nice, they [staff] are all very helpful." A relative talking about the positive interactions they had with staff said, "They are kind and have a laugh and joke with me."

We observed positive communication throughout the day between staff and people. However the majority of conversation was task focused. People were asked what they would like to drink with lunch and where they would like to sit. There was little incidental or social conversation; a missed opportunity for staff to develop relationships and their understanding of the people they cared for.

There were areas of good practice but it was not consistent and people's experience was not good. For example staff did not consistently use language that valued people. In addition we fed back to the manager one isolated incident we observed where a member of staff who was clearing up after the lunch time meal had leant over a person who was sitting in a wheelchair and scraped food from the floor stating, "I see you didn't want this then?." It would have been more dignified to move the person to another area before clearing the floor rather than working over them and making this derogatory comment. The manager responded that work had begun on improving staff approach through communications and planned training to address the inconsistencies we had found to ensure people's dignity was respected.

We did see positive staff engagements where they demonstrated empathy, understanding and warmth in their interactions with people. For example, in one of the units a member of staff was attentive to all those present in the dining room including one person who was becoming anxious. The member of staff sat with them, asked what was wrong. They explained things clearly to the person and provided reassurance in a meaningful way, which put the person at ease.

Autonomy and independence were not consistently promoted by staff. Opportunities were missed when staff took over jobs such as laying tables or pouring drinks from people who were willing and able to do them. As a result people became disengaged and withdrawn. People's records provided guidance to staff on the areas of care that they could attend to independently. However, in several instances we saw areas where this could be improved upon. For example, one person's care plan stated that when providing personal care they, "Require assistance", but it was not clear about what assistance was required, to ensure the person retained their independence as much as possible and their preferences were followed.

People's care records showed that they, and where appropriate their representatives had been involved in their care planning. Further work was needed to consistently reflect people's comments when the reviews were undertaken and where people's needs or preferences had changed.

People told us their dignity and privacy was promoted and respected. This included closing curtains and shutting doors before supporting them with personal care. In addition, when staff spoke with people about their personal care needs, such as if they needed to use the toilet, this was done in a discreet manner. One

person commented, "I had a bath last Saturday, really lovely and they [staff] let me be in there as long as I wanted, they do respect me."

Requires Improvement

Is the service responsive?

Our findings

Care plans required further development and improvement to reflect a person centred approach which focused on a person's whole life, including their mood and well-being. People received basic care, treatment and support that met their physical needs. Their care records reflected this approach. Documentation was focused on risks to people and keeping them safe. They contained limited information to guide staff on how to support people with other aspects of their lives such as meeting their emotional and social care needs.

Despite care plans being reviewed monthly, where there had been a sudden or significant change to a person's wellbeing this was not consistently reflected in their care records. For example one person's mobility had changed and they now required assistance but their records had not been amended.

Daily logs did not reflect a person centred approach. Entries were task focused listing personal care activities such as 'pad changed' to describe the person's daily experience and there was limited information about a person's mood or wellbeing.

Improvements were needed to ensure people who were more dependent including those living with dementia consistently had their social and cognitive needs met. People who remained in their bedrooms or were cared for in bed received limited social attention and were at risk of isolation as staff interactions were task focused.

There was one activity co-ordinator on shift responsible for providing activities and one to one engagement for people that lived in the service. Whilst we observed that there were some areas of good practice with regards to activities and social stimulation in the service we found inconsistences. This included where some people were left for long periods of time with little or no stimulation and they became withdrawn and disengaged.

Staff told us that regular safety checks were in place for people who did not leave their bedroom and those with more complex needs. They said they tried to spend quality time with people but acknowledged that records did not consistently reflect the engagement and activity provided. Whilst we did see one member of staff sitting talking to someone in their bedroom for a period of time we were not assured that an effective system was in place to ensure everyone received quality interaction to reduce the risk of isolation.

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

People were encouraged to maintain relationship with friends and family. One person told us how the staff would, "Take me down in the wheelchair to see my friend in [name of other unit]." A relative commented, "Staff have said you can come anytime you like, as early and as late." This demonstrated that staff were aware of the importance of social contact and companionship and focused on what was most important for individuals.

Not all people and relatives we spoke with were aware where the complaints process was displayed in the service or who to speak with if they needed to make a complaint. Some people told us they had spoken with the previous manager when they wished to raise a concern but did not know who they would speak to now the manager had left. People told us that as they had spoken to staff when issues emerged and these had been dealt with satisfactorily, they had not escalated matters further. One person's relative told us that they found the staff were, "Receptive," and, "Accommodating," when they had spoken with them about a problem with laundry management.

Systems for recording concerns and complaints were not robust. Issues were not consistently documented to reflect the actions taken, how this was fed back to the person and used to develop the service. Improvements were needed to ensure people's feedback was valued and acted on. The manager responded to our concerns by immediately reviewing the complaints process in light of our feedback. These included reviewing complaints to see what lessons could be learnt to improve the service.

Requires Improvement

Is the service well-led?

Our findings

The provider has been registered for Stradbroke Court since 4 September 2015. During this time there had been significant management changes and we received a high level of concerns relating to the safety and quality of the service. Because we were not assured that the provider had effective oversight and governance arrangements in place we met with the provider's nominated individual, their manager and other health and social care professionals 1 December 2016 to discuss these issues. The nominated individual told us they had identified a number of improvements required relating to the leadership and governance of the service and had taken steps to address this by appointing the manager. The manager had been in post since September 2016 and was in the process of registering with CQC. Further plans to restructure the senior support and management arrangements in Stradbroke Court were underway this included a new head of care position appointed to support the manager. In addition they were open to working with other professionals to improve the service.

At the time of our inspection we saw that these development plans were being implemented and were not embedded into the culture of the service. Therefore it was too early to see what impact these improvements were having on people and their experience of living in the service. In addition we found other shortfalls around quality and safety which the leadership had failed to identify for example the complaints process.

There was conflicting information from staff about their confidence in the leadership at Stradbroke Court. Some staff felt able to talk to senior colleagues whilst others felt they would not be listened to. Several of the staff told us they did not feel supported in their role and had not had regular supervision. We noted that there were regular staff meetings which most staff said were useful to finding out what was happening at the service. One member of staff said, "Given all the changes in staff and management, the staff meetings are the only way I find out what is going on." However several staff were positive about the manager and told us, "Now I feel supported by [manager], [they] are here three days a week things are getting better." Another member of staff said, "It would be better if the manager was here more. You can speak to [them]."

Not all the people and relatives we spoke with were aware who the manager was despite them being in post for three months. We expressed concern over the manager's capacity to be a visible presence, have effective oversight and governance for Stradbroke Court, when they were also the manager for another of the provider's services based in Norfolk. This service is also rated as requires improvement. The manager advised us that they were dividing their time between both services to oversee the required changes as reflected in the development plans for the locations. They added that they would be supported in their role by a revised management structure. This consisted of two new head of care posts working alongside deputy managers and team leaders in both services. These posts were due to commence the following week. They acknowledged that the task to address the shortfalls of both services was significant and the provider had given assurances that additional resources were available. The manager acknowledged the input in Stradbroke Court's development plan from the Local Authority provider support team which was ongoing and included support for further training and assistance with improving people's care records.

There was a lack of consultation with best practice guidance in relation to promoting an environment that

was enabling, safe and promoted wellbeing. People's needs had not effectively been considered in relation to dementia and how this affects their cognitive ability, impacting on their day to day living.

We found a task led culture with no clear lines of leadership and accountability during the shift. Delegation of work was ineffective and spaces within the service were not well used. In one of the units the dining room was overcrowded yet the day centre space was empty. A consistently supportive team atmosphere was not evident; some staff felt they could depend on their colleagues while others felt isolated and overwhelmed. When we asked a member of staff to attend to a person. We were told "[They are] not on my unit." The member of staff then left and asked another member of staff to assist the person.

Feedback from professional stakeholders was not always positive. One visiting professional to the service voiced their concerns, "Gone downhill since it first opened, we keep a good eye on it, been a few problems, with fluid charts, a diabetic patient not being given food in time and went to hospital. In our [professional] weekly meetings this place is mentioned. They [service] try to address things, couple of times they have not heeded our advice on fluid charts and the [carers] have been rude and offish and they don't point you in the right direction when we are here. The decline has been in the last three months and we have raised safeguarding issues." However the majority of stakeholders we spoke with acknowledged that the service was in transition, "Work in progress," and, "Improvements were ongoing."

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

Quality assurance systems were under review by the new manager. They shared with us their baseline assessment of the service they had recently carried out and how this was being used to identify shortfalls and to drive continuous improvement through a phased approach linked to risk management. In addition feedback from other stakeholder visits was reflected including actions taken to resolve issues. This included ineffective Legionella systems and unsafe management of medicines.

Where we found shortfalls in the service such as staffing arrangements, infection control procedures, inconsistent staff approach, complaints process and record keeping. The manager was open and transparent and took prompt action to remedy these issues. They demonstrated how they intended to use our feedback to make further improvements within the service and submitted a revised development plan which took account of our comments and included measures to mitigate the risk.

Following the inspection we received several updates on actions they had taken to address our concerns. This included attempts to resolve outstanding complaints which had occurred before they were in post and developing the services' complaints process to ensure it was fit for purpose and people's feedback was acted on.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans required further development and improvement to ensure they were person centred, accurate, met people's needs and reflected their preferences. Regulation 9: 3, a, b , c

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not consistently take appropriate action to mitigate and control the risk of infections. Improvements were needed to ensure incident reports reflected the specific strategies in place to reduce harm and reoccurrence. Peoples risk assessment reviews were not always accurate and updated when their needs had changed. Regulation 12: 1, 2 a, b, h

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust systems were not in place to effectively monitor and evaluate the safety and quality of the service to drive continual improvements. Regulation 17: 1, 2 ,a, b, c, d (ii), e, f

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Improvements were needed to ensure the deployment and organisation of staff during the shift was effective to meet people's needs.

Regulation 18, 1