Aura Care Living LTD

Stratton Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stratton Court is a residential care home providing accommodation to persons who require nursing or personal care, to up to 60 people. The service provides support to older people; some whom live with dementia. At the time of our inspection there were 58 people using the service. People are accommodated in one adapted building split over three floors.

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

People were not always protected from avoidable harm. People's care plans and associated records were not always current, accurate and did not provide staff with the correct information they required to safely meet people's needs.

Where people had specific care needs, staff did not always keep a clear record of the support they had provided, including fluids people had received as part of their assessed care.

Monitoring systems were not always effective as the records supporting the management of the service were not always reliable. These systems had not always identified or addressed concerns found during our inspection, including concerns in relation to people's care records, medicine management and fire safety.

People were placed at risk of not receiving their medicines as prescribed. Staff had not always ensured people had access to their prescribed medicines.

People told us they felt safe. They told us the staff were tolerant, patient and friendly. Although there had been challenges in recruiting staff, there were enough staff to ensure people's care needs were met.

There were a range of activities and events for people to enjoy. However, some people who were not mobile, or were living with dementia were not always supported to access or enjoy these activities. Additionally, while we observed there were enough staff to meet people's needs, staff did not always take the opportunity to engage with people and promote their wellbeing.

The provider, registered manager and staff had learnt from incidents and used this to inform their actions. A number of concerns identified at this inspection were immediately rectified by the management team.

People and their relatives felt the new manager was approachable, however had raised issues regarding communication. The provider was aware of these concerns and were aiming to improve communication with relatives and healthcare professionals.

Staff told us they felt supported and enjoyed working at Stratton Court. Staff had received training to meet people's needs and the homes management team were providing training to staff to improve

communication and engagement with people.

We were assured the service were working in accordance with current government COVID-19 guidance

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 27 April 2021).

Why we inspected
This inspection was prompted by a review of the information we held about this service. This included information of concern about people's care, support and medicine administration. We also inspected based on the rating of Stratton Court.
As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stratton Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, good governance and person centred care at this inspection.

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

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

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Stratton Court

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Stratton Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stratton Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there wasn't a registered manager in post. However, the manager was in the process of registering with CQC.

Notice of inspection
This inspection was unannounced. We inspected the care home on 28 and 29 June 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with fourteen people who used the service to learn about their experiences of the service provided to them. 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 also spoke with five relatives. We spoke with 16 members of staff. This included eight care staff, a unit leader, two housekeeping staff, a maintenance worker, the activities co-ordinator, the chef and two nurses (including an agency nurse). We spoke with the manager and three representatives of the provider. We also spoke with two healthcare professionals who visited the service and received feedback from another healthcare professional.

We inspected the care records of six people. We inspected three staff recruitment files and a selection of medicine and maintenance records. We reviewed records pertaining to the management and quality monitoring of the service. We requested and received copies of additional information, including infection control audits and complaints documentation.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question remains the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● People did not always receive their medicines as prescribed. We identified nine people who had been placed at risk of not receiving their medicines as prescribed in June 2022. When we counted people's individual medicine stocks against medicine administration records, we found more doses than we expected to find.

● Staff had not always identified when people had not received their medicines a s prescribed as they had not accurately checked people's medicine stocks.

● People were placed at risk of not receiving their medicines as prescribed medicines as medicines as staff had not always ensured that sufficient stock was made available. One person had a prescribed medicine which had ran out of stock seven days before our inspection. Despite this concern being raised, this prescribed medicine was not available. Another person's medicine had ran out of stock prior to our medicine, however there was no record that staff had arranged for this medicine to be available.

● Some people were prescribed medicines that where to be administered 'as requires' when they could be anxious or distressed. We reviewed five people's 'as required' protocols for these medicines. There was not always clear guidance for staff to follow, including when to administer these medicines and how to review the effectiveness of their prescribed medicines.

People had not received their medicines as prescribed. Staff did not follow recognised good practice when managing people's prescribed medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines were stored securely, and within appropriate conditions as per manufacturer guidelines. Where people received support with prescribed controlled medicines, these were managed safely and securely.

Assessing risk, safety monitoring and management

● Information about people's risks, including the risk of falling, had not always been documented. One person had been assessed as 'high' risk of falling. There was no care plan or guidance for this person on how staff should support them. The manager informed us this person required regular observations, however staff confirmed there was no current record of these observations. This meant the person could be placed at avoidable harm as there was not a clear plan to manage their assessed risk.

● One person was being supported to eat and drink at risk. The person was supported with drinks orally, as well as through a Percutaneous Endoscopic Gastronomy (PEG) tube (a way of supporting people with their nutritional needs when they are unable to orally take them safely). There was clear guidance for staff to

follow on their care plan, however there was not always a clear record of the care and support this person had received with their PEG regime as staff had not always followed the person's care plan.
● Service users were not always protected from the risks of their environment. The provider had not undertaken effective measures to ensure that service users would be protected from avoidable risk in the event of a fire. Fire checks had not been carried out in accordance with recommended good practice.

The provider and registered manager did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection we found concerns in relation to fire extinguishers that were no longer fit for purpose. We raised these concerns with the manager and a representative of the provider who took effective action, including replacing the fire extinguishers. They had also sought the immediate support and guidance of a professional in relation to fire safety.
● Staff, including agency staff understood and aware of people's needs. Where people were living with diabetes there was clear information on the support they required. Additionally those people assessed as being a risk to skin damage received the support they required to maintain their skin integrity.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. One relative told us, "I do feel the home is always clean."
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider was following current government guidance in relation to visiting at the time of the inspection. People and their families spoke positively about their experience of visiting throughout the pandemic.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt the home was safe. One person told us, "I do feel safe here."
● The manager and representatives of the provider were visible and regularly worked alongside staff and met people's visitors.
● Staff had read the provider's whistleblowing policy and procedures and felt able to report any concerns about poor practice or inappropriate staff behaviour.

Learning lessons when things go wrong
● During the inspection the manager and representatives of the provider took immediate action in relation to our concerns around fire safety and medicine management. This included starting audits on medicine audits to enable them to ensure people received their medicines as prescribed.

Staffing and recruitment

● Suitable staffing levels were in place to meet the needs of people using the service. The home used agency staff when required to ensure there were safe staffing levels. In response to recruitment concerns the provider had employed staff as part of a sponsorship scheme. This scheme was co-ordinated with the government. A representative of the provider was organising training for the staff to enable them to fill their roles effectively.
● People and their relatives had mixed views on if there were enough staff to meet their loved ones needs. Some relatives were not aware of action the provider had taken in recruiting staff to reduce inconsistent agency staff. One relative told us; "It feels as though there aren't enough staff, walking down the corridor and not finding anyone." The management discussed recent recruitment they had carried out as they had identified pressure on their own staffing team.
● Staff told us there were enough staff and they had the time they needed to provided people's care. Comments included; "I feel there are enough staff, there is nothing that makes me feel it's unsafe" and "Staffing is getting better, we have had struggles."
● Staff were recruited safely. All required checks were made before new staff began working at the home. Disclosure and Barring Service (DBS) checks were completed alongside seeking references from staff's previous employers. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Appropriate recruitment checks had not always been fully documented prior to staff starting work. Reference checks from staff's previous social care employers had been sought to gather assurances around staff conduct however there was not always a clear record of this. One staff personnel file did not contain references from people's previous employment in care services.

We recommend the provider, review their recruitment processes and documentation to ensure they have the appropriate records.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always support person centred care as they were not an accurate reflection of people's needs or preferences. One person could become anxious and physically aggressive. There were no behaviour care plan or detailed guidance for staff to follow on how they should support the person when they are distressed. One member of staff told us, "Staff don't have specific training to support [person]. There are no guidelines and we do our best to support them."
- Another person could become anxious, however there was no clear details on the support they required. There were not current records of incidents and staff had informed us the person was settled at Stratton Court. We asked the manager if there were behaviour care plans for people. Copies were provided to us, however these were not detailed and were not accessible to care and nursing staff.
- Care staff and other staff did not always have a consistent approach to meaningfully engaging with people and providing positive interactions. For example, on one unit we observed people went for a period of time up to an hour without any engagement from staff. During this time eight people were in their own rooms. We observed two staff enter people's bedrooms without acknowledging the person. One person was calling out, however there was not always a timely response from staff in response to their request.
- There were activities and events arranged on a daily basis for people living at Stratton Court. However, for those people who were immobile or were living with dementia there was not always appropriate engagement and support. We observed that staff did not always take time to provide meaningful engagement for people. Additionally, care notes for some people indicated they did not always benefit from effective stimulation which met their need.
- People had not always been informed of activities and events. One person we spoke had not been told by staff that a whole home activity was going on. They said, "I haven't been told about the animals today. I would've liked that."
- We discussed these concerns with the management team, who took some immediate action to ensure staff were engaging people appropriately. One nurse told us, "We're not always taking that opportunity to engage, we've realised that." A representative of the provider also informed us that training was being provided to staff around engaging effectively with people. This was being led by a senior member of care staff. They told us, "I'm providing training to new staff. This will help improve people's wellbeing."

People did not always receive care which was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were a range of events and activities for people living at Stratton Court. During our inspection people were enjoying a visiting petting zoo. Mindsong (a local charity reaching people with dementia through music and song) also visited the home to provide singing sessions for all residents. A church service was also carried out during the inspection.
● People told us they enjoyed these activities and spoke positively about the activity co-ordinator. Comments included: "The activities man is really good and always so enthusiastic", "The Vicar comes in and holds a service here each week" and "There are things to do, which I enjoy."
● The activity co-ordinator had implemented activities for each unit, which included pictorial pages, word puzzles and activities sheets. These were placed for people to use, with the support of staff.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Each person's communication needs had been recorded as part of their care plan. This included the support the person needed to communicate and make choices. Staff spoke positively about how they engaged with people and supported them to communicate.
● Two people did not speak English. Pictorial guides had been developed by the activity co-ordinator to help care staff engage and communicate with these people, and support them to communicate their choices.

Improving care quality in response to complaints or concerns
● People and their relatives told us they did not always know how to make a complaint to the service. Two relatives told us they were unsure of how to make a complaint. We discussed this with the manager and representatives of the provider who were planning to meet with relatives and send a newsletter which would contain information on making complaints.
● The manager and provider kept a complaints tracker. This documented the action they had taken in response to complaints, concerns and any compliments. For example, action was taken in response to lost property. Action was taken to prevent a reoccurrence of this concern.

End of life care and support
● People were cared for at the end of their life through the service working in partnership with health professionals. Staff spoke positively about end of life care and ensuring people receive the care and support that is important to them, including being visited by their loved ones.
● Where people had recorded their wishes for their end of life care this was known by the service. One person had clearly documented their views on the end of their life and the medical support they required.
● The service worked with healthcare professionals to ensure people were comfortable at the end of their life. Where relevant, anticipatory medicines had been prescribed by people's healthcare professionals.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Audits and management systems were not always effective at identifying concerns. Audits in relation to the premises had been carried out in March and May 2022, however these had not identified concerns in relation to fire safety we identified during our inspection. Medicine audits carried out in June 2022 had not identified concerns in relation to people receiving their medicines as prescribed and 'as required' medicine protocols.
- Medicine audits had identified concerns around people's prescribed medicines not always being available. While this concern had been raised, effective action had not always been taken to address these concerns. One person was still not receiving one of their prescribed medicines, despite this being raised as an action to complete.
- The provider and manager did have effective systems in place to ensure the quality of care people received was meeting their expectations. Concerns we identified regarding people's ongoing care risks, the care and treatment they received had not been identified by at this inspection.

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

- The manager and representatives of the provider responded to concerns identified at this inspection, carrying out immediate action where necessary to reduce the risk to people living at Stratton Court.
- The manager carried out audits in relation to infection control which helped to ensure staff worked in accordance with government COVID-19 guidance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- During the inspection we identified occasions where staff were not engaging or acknowledging people living at Stratton Court. We discussed this with the manager and representatives of the provider. They had identified the need for additional staff training around engagement, particularly for new staff who were new to the country and the culture. A clear plan of training was being implemented, with support being provided by senior care staff.
- Management were visible in the service and approachable. We observed management, including staff employed at Stratton Village (although not directly the care home) engaging people and providing support. One member of staff supported people at lunch time, providing clear leadership and support to care staff.

● Staff told us they felt able to raise concerns with the manager without fear of what might happen as a result.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager and provider understood their responsibilities to be open, honest and apologised if things went wrong. Records showed relatives were contacted appropriately to inform them of incidents or near misses affecting their family member. Where learning had been taken following incidents, this had been shared with people's relatives and their views sought.

● The registered manager made sure CQC received notifications about important events so we could monitor that appropriate action had been taken.

Continuous learning and improving care; Working in partnership with others, Engaging and involving people using the service, the public and staff, fully considering their equality

● People and their relatives felt there were improvements being made at Stratton Court, they spoke positively about the new manager. One relative told us, "They are approachable." However, some relatives told us they had not received appropriate communication. The manager and representatives of the provider were implementing new systems to seek the views of relatives as well as communicate changes. This includes an open session with the manager.

● Healthcare professionals shared mixed feedback on the service. Some professionals raised concern in relation to medicine management. Comments included: "Overall I think it is improving and that is generally due to better management over the last few months. There are still areas for improvement" and "There are some improvements, we are working with them."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care, support and engagement which was tailored to their individual needs.

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	People had not always received their medicines as prescribed. The provider had not ensured people were always protected from the risks associated with their care.

The enforcement action we took:

The Care Quality Commission (CQC) has issued a warning notice for breach of Regulation 12 in relation to the care provided at Stratton Court.

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	The registered person had failed to apply effective governance to ensure quality of care for people was appropriate.

The enforcement action we took:

The Care Quality Commission (CQC) has issued a warning notice for breach of Regulation 17 in relation to the care provided at Stratton Court.