Bupa Care Homes (CFHCare) Limited

Stadium Court Residential and Nursing Home

Inspection report

Greyhound Way
Stoke On Trent
Staffordshire
ST6 3LL
Tel: 01782 207979

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Stadium Court Residential and Nursing Home on 17 and 20 October 2014. Stadium Court is registered to provide accommodation and nursing care for up to 168 people. People who use the service have physical health and/or mental health needs, such as dementia.

At the time of our inspection 135 people were using the service over four separate units (Wade, Stafford, Spode and Aynsley).

The service had a registered manager in post. 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.

Medicines were not always ordered, stored, administered or recorded effectively and safely.

Summary of findings

People's risks were assessed, monitored and reviewed. However people's risks were not always managed in accordance with their care plans. This meant people did not always receive their care as planned.

People's confidential information was not always stored securely which meant there was a risk that people's information could be misused or lost.

The provider ensured their minimum staffing levels were met, but we found that people did not always receive care and support in a timely manner. We have recommended that the provider reviews their staffing levels.

Staff understood people's nutritional needs. However, people's mealtime experiences were not always positive or pleasant. We have recommended that the provider improves people's mealtime experiences.

Leisure and social based activities were not consistently promoted or provided. We have recommended that improvements in activity provision are made.

People told us the staff treated them with kindness, compassion, dignity and respect. The staff encouraged and enabled people to make decisions about their care by giving people information in a manner that reflected their understanding.

Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed.

The staff received regular training and their learning needs and competencies were monitored by the managers to ensure they had the knowledge and skills required to meet people's needs.

The staff understood and followed the reporting procedures in place to raise concerns about people's safety. People's health and wellbeing was assessed and monitored and advice from health and social care professionals was sought when required.

The registered manager was working to make improvements to the standards of care and systems were in place to gain and respond to feedback about the quality of the care.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Systems were not in place to ensure people received their medicines safely, and people did not always receive their care in accordance with their care plans.

The provider's minimum staffing levels were met, but we saw that people did not always receive care or support in a timely manner.

Staff knew how to report any safety concerns and showed a good understanding of how to manage the risk of preventable infections.

Is the service effective?

Requires Improvement

The service was not consistently effective. People received a balanced and varied diet. However mealtimes were not always a pleasant experience.

Staff received training that enabled them to provide care and support. People's health and wellbeing was monitored and other professionals were consulted with to ensure people received medical, health and social care and support when required.

When people did not have the ability to make decisions about their own care the staff followed the legal requirements that ensured decisions were made in people's best interests.

Is the service caring?

Good

The service was caring. Care was delivered with kindness and compassion.

People were treated with dignity and respect and their right to privacy was independence was promoted.

The staff enabled people to be involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Leisure and social based activities were not consistently promoted or provided.

People and their relatives were involved in the assessment and review of their care to ensure there was a record of their care preferences.

The provider sought, listened to and acted upon feedback from people who used the service to improve care.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Improvements were required to ensure effective quality assurance systems were in place.

The provider was open and managers were approachable and friendly.

Summary of findings

The provider and management team were committed to improve the quality of care. Plans were in place to show this.	

Stadium Court Residential and Nursing 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 checked 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 inspection took place on 17 and 20 October 2014 and was unannounced.

Our inspection team consisted of five inspectors, a pharmacist inspector, a specialist advisor with specialist knowledge of nutrition and hydration and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and also checked the information we held about the service and the provider.

This included the notifications that the provider had sent to us about the care and information we had received from the public and the local authority. We used this information to formulate our inspection plan.

Before our inspection we also spoke with the local authorities safeguarding and commissioning teams to identify if there were any current concerns. We were told that there was one open safeguarding concern that was in the process of being investigated.

We spoke with twenty two people who used the service and 12 relatives. We also spoke with eight nurses, 17 members of care staff, the cook, the registered manager, deputy manager and the area manager.

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 21 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, health and safety checks, staff rotas, training records, five staff recruitment files and minutes of staff meetings. We did this to check how the service was managed.

Requires Improvement

Is the service safe?

Our findings

We found that medicines were not always ordered, stored, administered or recorded safely. The ordering process for obtaining medicines did not always ensure people had their medicines when they required them. For example, two people had not received one or more of their medicines because the provider had not obtained them in sufficient time.

Effective systems were not in place to check that medicines were stored within the manufacturers recommended temperature range. On Stafford unit we saw that the temperature had dropped below the recommended range and no action had been taken. This meant that people could not be assured that their refrigerated medicines would be safe or effective.

Where people needed to have their medicines administered by disguising them in food or drink, the necessary safeguards were not in place to ensure these medicines were administered safely. The staff could not show that advice had been sought to check that the food and drink medicines were being mixed with were appropriate and safe.

We looked in detail at 12 medicine administration records (MAR). MAR's were not always signed and completed correctly to maintain an accurate record. Also, the quantities of medicines listed on people's MAR did not always match the numbers of medicines stored at the home. This meant people could not be assured they were receiving their medicines as prescribed by their doctor.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Effective systems were not in place to protect people from the risks associated with their medicines.

We visited five people who were being cared for in their bedrooms. We found that four of the five people did not have access to their emergency call bell system because it was out of reach. One person who was seated in their chair in their bedroom with their call bell out of reach told us they felt unwell. Staff confirmed that this person could use their call bell if it was within reach. We intervened and summoned assistance on their behalf. This meant that some people were unable to call for assistance when they needed it, placing them at risk of harm.

We saw that people's risks were assessed and reviewed regularly and incidents were investigated and managed. However, we saw that people's risks were not always managed as planned and people could not be assured they would receive safe and consistent care. For example people did not always receive the support their care records showed they needed to manage the risks associated with the use of the hoist and walking. We observed staff assisting two people to use the hoist using a different sling from the type recorded in their care records. We asked four staff members which sling they needed to use for one of these people and only two of the staff's answers matched the information in the person's care record. This meant that people did not always receive care and support in a manner that ensured their welfare or safety.

Prior to our inspection we received information that alleged poor practice in relation to infection prevention and control. We saw that systems were in place to protect people from the risks of preventable infections. People who used and visited the service told us they were happy with the standards of cleanliness. One relative said, "[The person who used the service] room is always clean and tidy". Another relative said, "It's always very clean when I visit and I visit every day". Staff we spoke with told they used protective equipment such as aprons and gloves when providing personal care and they said this equipment was readily available.

People we spoke with told us they felt safe. One person said, "The whole place is very secure and I do feel safe here". Another person said, "I think I'm safe, the staff are very good". Procedures were in place that ensured concerns about people's safety were appropriately reported. The staff we spoke with explained how they would recognise and report abuse and we saw that suspected abuse was reported in accordance with the local reporting procedures.

Procedures were in place that ensured any concerns about people's safety were appropriately reported. The staff we spoke with explained how they would recognise and report abuse and we saw that suspected abuse was reported in accordance with the local reporting procedures.

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

Requires Improvement

Is the service safe?

of the staffs' characters and their suitability to work with the people who used the service. Regular checks were also made to ensure nurses were correctly registered with the Nursing and Midwifery Council.

The provider had a system in place to identify the minimum numbers of staff required and rotas showed that the provider's minimum staffing numbers were met. The registered manager shared examples of how they had used agency staff (temporary staff) and bank staff (staff employed by the provider for occasional work) to provide cover for staff absences and emergencies. This showed that systems were in place to ensure the provider's minimum staffing levels were maintained in the event of staff absence or emergencies. However, people and staff told us and we saw that people's needs were not consistently met in a timely manner.

One person told us, "I told them I wanted the toilet when Morse [A television programme] started and it's just about to finish now. I've waited over an hour". A relative said, "Some people have to wait a long time for the toilet. There's just not enough staff". On one unit we saw one person ask for the toilet at 10:30am. This person was still waiting at 12:05pm when the observing inspector left the area. Staff we spoke with also told us there were delays in providing care and support. One staff member said, "There are not enough staff. The residents don't always receive the care they need".

We recommend that the provider reviews staffing levels to ensure there are sufficient numbers of suitable staff to keep people safe and meet their needs

Requires Improvement

Is the service effective?

Our findings

People told us and we saw that meal choices were offered. One person said, "I always get a choice of what to eat". A relative said, "There is always a choice of food and it's warm enough to eat".

Specialist diets such as; Halal, gluten free and soft diets were provided and meal portions were variable to meet people's individual nutritional needs. Staff demonstrated they understood people's dietary needs and we saw that people's dietary needs and preferences were met.

We saw that staff knew how to support people to eat and drink. However, people's dining experiences were not always pleasant. For example, on Stafford Unit, there were not enough chairs and tables to enable everyone who wanted to eat in a dining room to do so. We saw that one person was redirected away from the dining area to the lounge when there was no space for them to eat. We also saw three staff members kneel on the floor to assist people to eat because there were no chairs available for them to use.

The staff demonstrated they understood the action they needed to take if a person's weight had changed. People's care records showed that doctors and dieticians were consulted with in the event of a person being identified as at risk of losing too much weight.

Staff received training that enabled them to provide care and support. Training topics included; safeguarding people, moving and handling, infection control and behaviour that challenges. Training records showed that staff were up to date with the provider's essential training and the staff we spoke with were able to tell us how they applied their training in their roles. For example staff told us and we saw that they had applied techniques to manage behaviour that challenged when a person who used the service presented with these behaviours.

Effective systems were in place to support staff who were new to care or new to the service. A new staff member told us, "I was really impressed with my induction. It covered all the common induction standards over a whole week of training. I then shadowed for two days and was assigned a mentor for support". We saw that new staff received a structured induction which was based around achieving the Skills for Care 'Common Induction Standards'. These are the national standards people working in adult social care need to meet before they can safely work unsupervised.

The rights of people who were unable to make important decisions about their health or wellbeing were protected. Staff understood the legal requirements they had to work within to do this. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The staff demonstrated they understood the principles of the Act and the DoLS and they gave us examples of when they had applied these principles to protect people's rights. We identified one person who had a DoLS authorisation in place. The staff understood the reasoning behind this and their role to protect this person. Care records confirmed that mental capacity assessments, DoLS referrals and best interest decisions had been made in accordance with the legal requirements.

Assessment and monitoring tools were used to enable the staff to identify changes in people's health and wellbeing. For example we saw that staff requested reviews of people's mental health medicines when their mental health improved. This showed there was a system in place that ensured people were not over medicated. We saw that this had led to a reduction in one person's medicines with no negative effects on their behaviours or health. People were able to access health, social and medical support when they needed it. For example, we saw that visits from doctors and other health professionals were requested when people became unwell or their condition had changed.

We recommend that the provider explores the relevant guidance on how to make mealtimes a positive experience for people who use the service.

Good

Is the service caring?

Our findings

People told us and we saw that staff treated people with kindness and compassion. One person said, “The staff are lovely and they can’t do enough for us”. Another person said, “The staff are all very nice and they treat me well”. We observed positive and caring interactions between people and staff. For example, we saw a staff member make one person comfortable in their chair by gently tucking a blanket around them and lifting their feet onto a foot stool at their request.

People told us and we saw that staff used their knowledge of people’s interests and life histories when they provided care and support. For example, we saw a staff member talk to one person about their previous occupation when they tried to encourage the person to eat.

The staff involved people in making choices about their care. People told us that they made choices about their care. One person told us that they chose the times they went to bed. They said, “I like to get up at 8:00am and go to bed no later than 9:00pm so I can get a good night sleep”. We saw that people were given choices. For example, we saw one staff member ask a person, “Would you like me to use a fork or a spoon when I help you”. We saw that the choices people made were respected by the staff.

People told us that staff helped them to understand information about their care. One person said, “They tell you what your tablets are and what they are for”. This showed staff helped people to understand information to enable them to make informed decisions about their care.

The staff treated people with dignity. On one unit we saw that the staff used a blanket to cover one person’s legs whilst they were being assisted to use the hoist so that their dignity was promoted. Throughout our inspection we saw that staff knocked on people’s doors and waited for a response before they entered their rooms and doors were closed when care was being delivered to promote people’s privacy and dignity.

The relatives we spoke with told us that the staff made them feel welcome and involved them in care decisions. One relative said, “I always feel welcome on the unit”. Another relative said, “I’m able to have a hands on role in [Their relative] care. It’s what me and [Their relative] want”.

We saw that relatives were offered emotional and psychological support to help them understand their relative’s medical condition. One relative said, “The staff seek me out even though I tend to isolate myself”. Staff told us that they could refer people who used the service and their relative’s to an admiral nurse for support. An admiral nurse is a specialist dementia nurse who provides support to promote emotional wellbeing and equip people and their relatives with the skills and information to help them to understand and manage dementia.

Requires Improvement

Is the service responsive?

Our findings

We observed activity coordinators engage with a small number of people who used the service and we saw that staff and relatives assisted some people to access the service's onsite tuck shop. However, people and their relatives told us that leisure and social based activities were not consistently promoted or provided. One person who used the service said, "It can be boring here, there's often nothing to do". A relative said, "There is nothing for people to do. I come in most days at different times and I rarely see any type of activity".

Staff also told us that they did not have time to enable people to participate in their preferred leisure and social activities. One staff member said, "We just don't have the time to interact with people and chat". Another staff member said, "It makes me feel stressed because I don't have the time to provide any stimulation or just sit and chat to residents". Another staff member said, "There isn't enough staff. We can't give people 100 percent and we have to rush, activity provision suffers because of this". The registered manager was aware of shortfalls in activity provision and had planned to improve this. For example, a plan was in place to introduce a 'man shed' at the home which they planned to fill with male related memorabilia. The registered manager told us this would help to address the shortfall in activity provision for some of the males who used the service.

People told us and we saw that people and their relatives were involved in the assessment and review of care. This enabled the staff to gain information about people's care preferences. Care records contained information about people's likes, dislikes and preferences and staff demonstrated that they were aware of this information. For example, one person liked toast without crusts and we saw that their toast was provided in accordance with their preference.

People's relatives and friends could visit at any time and they were able to play an active role in care provision if the person consented to this. For example, one relative told us that they assisted their relative to eat and drink as this had been agreed with the person who used the service and the staff.

We saw that people who used the service and their relatives were given the opportunity and were supported to express their views about the care through meetings and surveys. Daily meetings were held by the registered manager where people's feedback could be shared. We saw that the registered manager listened to people's feedback and took action to make improvements. For example, a recent concern had been raised about the intrusive position of a skip outside one of the units. The registered manager took action to move the skip to a less intrusive position.

There was an accessible and effective complaints process in place that enabled improvements to be made when required. People and their relatives told us they would be happy to approach staff to share concerns or make a complaint. One relative said, "I don't have any complaints but I would speak to manager if I did". Another relative told us, "I go to the manager to raise concerns. She always makes time to see me". Records showed that complaints were managed in accordance with the service's complaints policy.

We recommend that the provider explores the relevant guidance on how to enable people to engage in purposeful leisure and social based activities.

Requires Improvement

Is the service well-led?

Our findings

We saw that the registered manager and provider assessed and monitored the quality of care. Frequent quality audits had been completed. These included audits of; care records, infection control, the environment, privacy, dignity and medicines. These audits were evaluated and where required action plans were in place to drive improvements. However, these audits were not always effective in identifying quality concerns. For example, the provider's medicines audits had not identified the concerns with medicines management that we found.

We saw that care records audits were ineffective as they did not always identify recording errors. Our specialist advisor identified errors on five of the seven nutritional assessment and monitoring charts they looked at. For example the weight loss of one person was not correctly calculated which resulted in an incorrect assessment score. Care records audits had also not identified that people's care records were not always being stored securely. We found that people's care records on Stafford and Wade units were not stored securely. This meant people's personal and confidential information was not kept secure and the information contained in people's care records was not protected from potential damage or loss.

People who used the service and their relatives told us the managers were friendly and approachable. One relative said, "I've been really impressed with [The unit manager]. They have been welcoming, friendly and seem knowledgeable". Another relative said, "[The unit manager] is very good". Staff also told us that managers were approachable and they would feel confident to share any concerns about care with them. One staff member said, "I happily approach the manager when I need to". This showed that the service had an open culture.

We saw that systems were in place that enabled the registered manager to gain feedback about the service from the staff. Staff were encouraged to meet with the registered manager if required and a 'you said, we did' board was located in a staff area where staff could write their feedback and the managers could write the actions taken in response to the feedback. This showed that the registered manager was responding to some of the feedback made by the staff.

The registered manager and their deputy were both new in post. The registered manager told us, "We are a new management team, but we are very positive and we are working well together". They showed us an action plan they had formulated to address the initial areas for improvement that they had identified after commencing in post. We could see that some of the actions had been achieved. For example, improvements had been made to the garden areas and dementia training had been rolled out. We could also see that progress was being made to meet the other actions on the plan. This included the re-introduction of staff appraisals. This showed that the registered manager was working to improve the standards of care.

The staff told us that their learning and development needs were assessed, monitored and met through regular supervision and training. One staff member said, "I find supervision very helpful". The location had its own dedicated trainer who monitored and managed people's training needs. The registered manager over saw this process to ensure training standards were met.

The managers demonstrated they had a good knowledge of the care provided which showed they had regular contact with the staff and the people who used the service.

The registered manager notified us of reportable events as required. For example, we were informed of deaths that occurred at the service and incidents that resulted in a serious injury. This showed that they understood their CQC registration responsibilities.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected from the risks associated with medicines. Effective and safe systems were not in place for the ordering, storage, administration and recording of medicines. Regulation 13.**