Runwood Homes Limited

Stafford Hall

Inspection report

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Date of inspection visit:
13 July 2021

Date of publication:
19 August 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stafford Hall is a residential care home providing personal care and support for up to 40 older people some of whom may be living with dementia. At the time of our inspection 27 people were using the service. The service is set in an adapted building over two floors.

Risk assessments needed to be clear and identify the support people required to keep them safe. Clear guidance on how best to support people needed to be implemented for staff to follow.

Safeguarding concerns are required to be raised with the local authority and fully investigated, so lessons learned can be shared in a meaningful way with staff. Better systems needed to be implemented to ensure this happened.

Staffing requirements need to match the needs of the service and people living there. Contingencies needed to be put in place when staffing numbers reduced at short notice, to ensure there continued to be enough staff present to support people safely day and night.

Governance at the service needed to improve to ensure this was meaningful and reflected an accurate oversight of the service to manage and mitigate risks.

People's experience of using this service and what we found
We had a mixed response of views from people and their relatives, concerns were mostly voiced over staff shortages. However, people and relatives were complimentary of the staff team.

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

Rating at last inspection: The rating at the last inspection was Good (published 17 March 2020).

Why we inspected: The inspection was prompted in part due to concerns received around safeguarding and risks to people. A decision was made for us to inspect and examine those risks.

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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Infection Prevention and Control, staff training and governance.

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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Stafford Hall

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 Care Act 2014.

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
There were two inspectors in the team.

Service and service type
Stafford Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, however they had recently stepped down and a new manager was in the process of becoming registered. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We did review information we held on the service since the last

inspection and information we had received from the local authority.

During the inspection-
We spoke with eleven people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the regional operations director, manager, deputy manager, care workers and the chef. 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 reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including accident/incidents and audits were reviewed.

After the inspection
We continued to review action plans and reports sent to us by the regional operations director.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. 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.

Assessing risk, safety monitoring and management

- Risks were not always assessed and monitored safely.
- The service had a number of assessment tools in relation to risk and we found the ratings on each tool were not always consistent. For example, one person had a high-risk rating of falls which reduced to a medium risk on another part of the assessment which was in conflict with the initial rating. The manager told us that risk assessments will be one of the areas they will be reviewing and updating.
- We observed one person to begin to choke on their lunch. Staff quickly intervened to support them to clear their airway. We asked staff if the person was being supported with a special diet which they said they were not. When we observed their food, they had pieces of chicken, mash and runner beans with mixed diced vegetables. We checked the nutritional support plan which said they preferred softer food as they did not have dentures.
- Another care plan we reviewed identified a person could become verbally abusive to their relative and staff, there was no guidance for staff to follow on how to respond and support the person if this happened.
- Following a previous incident where a person had gained access to stairs leading to the first floor and had fallen down these stairs, a new stair gate had been fitted at the bottom of the stairs with a lock. We found on two occasions this stairgate was left open, which meant people remained at risk of falling on the stairs should they access this area. We reported this to the manager.

This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment

- The service had on numerous occasions not been able to maintain the correct level of staff on each shift. Staffing numbers were calculated against the needs of people using the service.
- We saw evidence from staff rotas that there were times when staff worked below the calculated numbers mostly at night and during the afternoons.
- Staff told us they had been working with staff shortages mainly in the afternoon and they had felt pressure during these times to support people.
- One issue highlighted was there was no kitchen staff after 3pm. Which meant a member of support staff would need to be taken away from care to provide the evening meal service and clear up. Staff told us this caused pressure on them when they were already working a member of staff down.
- A relative told us, "They are often short of staff, it is worse at the weekends." One person told us, "It is alright here, but I think there is a problem with staff shortages. I need help to get to bed. I ring my buzzer and

they come after a time. I think they come as soon as they can, but it can be a wait."

Effective arrangements for staffing cover had not been sought. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us they were addressing the staffing issues at the service and were actively recruiting new care staff and kitchen staff. The regional operations director told us they were looking at staffing numbers and would have contingency put in place to cover shifts including using regular agency.
● We reviewed staff files and saw safe recruitment practices were in place, including checking references and obtaining disclosure and barring service checks.

Systems and processes to safeguard people from the risk of abuse
● There was a system in place to do internal investigations on safeguarding concerns. However, this system had not identified that safeguarding referrals to the local authority had not been received or investigated. This placed people at risk, if no external investigations were being completed to ensure people's well-being and safety.
● The new manager was working with the local authority to ensure all safeguardings were now being raised correctly and investigated.
● Staff had received training in safeguarding and knew how to raise concerns. One member of staff said, "I have had safeguarding training. If I thought somebody was being abused I would go straight to the manager, regional manager or human resources."

Using medicines safely
● People were supported to take their medicines safely.
● Medicine records we reviewed were in good order. There were suitable systems in place for the storage, ordering, administering, monitoring and disposal of medicines.
● Regular audits were completed to check medication were being managed safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● The provider had a number of tools for registered managers to use to learn lessons when things go wrong. From documents we reviewed we were not always reassured that analysis was effective in preventing further risks. For example, low staff numbers had not been connected to an increase in unwitnessed falls.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The provider's systems for monitoring the safety and quality of the service were not effective.
- Safeguarding referrals had not been investigated by the local authority due to the registered manager sending these to an inactive email. Although internal investigations were completed, and lessons learned shared with staff. The provider's system for monitoring safeguarding referrals and how these were actioned had not identified that no independent investigation was taking place to keep people safe.
- Audits of people's weight did not provide an action plan or interventions when weight loss continued. Weights for the June audit had not been recorded correctly and had been a copy of the previous month's weight and actions.
- The accident and incident analysis did not take into account the affect of less staff resulting in an increase of falls during the afternoon and night. There was no action plan in place to address the issues of accidents and incidences instead the analysis for falls stated, 'had another fall'. There was no clear guidance on how risks were going to be mitigated for people.
- Support plans needed to be consistent in identifying the support people needed and give clear guidance to staff on how best to support people.

The provider had not ensured effective processes were in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider understood their responsibilities under duty of candour to be open and honest when something goes wrong. We saw evidence that the provider had taken action and was working with stakeholders including relatives, people, police and the local authority to investigate concerns that had been raised.

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

- The manager told us as part of their review of people's support plans, they would ensure people's equality

characteristics were supported.

● The service had continued to engage with people and relatives with meetings, some held over video calls. Feedback and action plans from meetings needed to be put in place.

● The service had worked in partnership with other health professionals such as district nurses and GPs to have people's health needs reviewed when required.

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 17 HSCA RA Regulations 2014 Good governance Governance systems needed to be more robust to identify and action issues identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers needed to be maintained to match the need of the service

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 People were at risk of unsafe care due to poor risk assessment procedures and actions.

The enforcement action we took:

Issued warning notice