Bupa Care Homes (CFHCare) Limited

Stadium Court Care Home

Inspection report

Greyhound Way
Stoke On Trent
Staffordshire
ST6 3LL

Tel: 01782450624

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21 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 19, 20 and 21 September 2017. At our previous inspection in December 2016 we identified a number of Regulatory breaches and we told the provider that immediate improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and was placed into 'special measures'. We also placed a condition onto the provider's registration that prevented them from admitting new people to the service. We then re-inspected the service in April 2017. At that inspection, we identified that some improvements had been made. However, we also identified two continued Regulatory breaches. We warned the provider that they needed to become compliant with these regulations by 31 July 2017 and the condition preventing new admissions to the service remained in place. The service remained inadequate in the Well-led domain; therefore the service remained under special measures. You can read the reports from our previous inspections, by selecting the 'all reports' link for Stadium Court Care Home on our website at www.cqc.org.uk.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service is registered to provide accommodation and personal care for up to 168 people. At the time of this inspection, care was delivered to people across four separate units. These units were named; Spode, Stafford, Wade and Wedgwood. Spode, Stafford and Wade units provided long term care to people and Wedgwood unit provided short term care and rehabilitation. People who used the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection 116 people were using the service.

At this inspection, we found that the required improvements had not been made and we identified new and continued Regulatory breaches. The service has been rated as 'inadequate' overall and will remain in special measures.

The home did not have a registered manager. However, the newly appointed home manager had applied to be registered with us and their application was being assessed at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

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

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

Staff were not always effectively deployed to consistently meet people's needs in a safe and timely manner. Staff, in particular agency staff did not always know people's individual needs and care preferences in order to provide safe and responsive care and support.

Incidents of potential abuse and neglect were not always recorded and reported in line with local and national guidance. This meant people were not always protected from the risk of abuse and neglect.

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

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

People's capacity to consent to their care was not always assessed and we could not always see that the requirements of the Mental Capacity Act 2005 were followed when people were unable to consent to their care. Some people had restrictions placed upon them that had not been assessed and planned for to ensure their rights were protected. We saw that restrictions placed on people were not always requested through the Deprivation of Liberty Safeguards (DoLS) when people could not consent to their care.

People were not always involved in the assessment and planning of their care. This meant people sometimes received care that did not meet their care preferences.

Staff did not always provide care and support in a manner that promoted people's dignity. People were not always supported to make choices about their care.

Social and leisure based activities were promoted. However, some people felt these did not always meet their individual needs.

Written complaints were managed in accordance with the provider's policy. However, effective systems were not in place to ensure verbal complaints were consistently recorded and acted upon to improve people's care experiences.

Safe recruitments systems were in place. However, improvements were needed to ensure the provider could assure people that agency staff were suitable to work at the service.

People were provided with food and drink. However, staff did not always support people to make informed meal choices.

People's right to privacy was promoted.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not managed safely and risks to people's health, safety and wellbeing were not always assessed, planned for and managed to promote their safety.

Staff were not always suitably informed or deployed effectively to meet people's needs in a safe and timely manner.

Staff knew how to recognise and report abuse. However, incidents of potential abuse and neglect were not always reported to the local safeguarding team as required.

Improvements were needed to ensure checks were completed to ensure all staff were suitable to work at the service.

Is the service effective?

Inadequate

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

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

People's capacity to consent to their care was not always assessed and the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not always followed. This left people at risk of receiving their care in an unlawful and restrictive manner.

People were provided with food and drink. However, staff did not always support people to make informed meal choices.

Is the service caring?

Inadequate

The service was not consistently caring. People were not always treated with dignity and respect.

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

Some staff knew people well which enabled them to have positive interactions with people. However, on Wedgwood unit, staff did not always know basic information about people and their care needs. This placed people at risk of receiving unsuitable and unsafe care.

People's right to privacy was promoted.

Is the service responsive?

Inadequate

The service was not responsive. People were not always involved in the assessment and planning of their care.

People did not always receive prompt support in accordance with their care preferences and needs.

People could participate in social and leisure based activities. However, improvements were needed to ensure these were meaningful to each individual.

Written complaints were responded to and acted upon to improve people's care experiences. However, improvements were needed to ensure verbal complaints were recorded and managed effectively.

Is the service well-led?

Inadequate

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

Effective systems were not in place to ensure action was taken to improve the quality and safety of the care people received.

Feedback from people about their care was not always sought to ensure any quality or safety concerns were acted upon.

Staff did not always feel supported by the management team.

Stadium Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of Stadium Court on 19, 20 and 21 September 2017. Our inspection team consisted of five inspectors, a medicines inspector and two experts by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service.

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

We spoke with 23 people who used the service, 12 people who visited relatives at the service and two visiting health care professionals. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with staff who worked at the service to gain their feedback about the care and to check they knew how to keep people safe and meet people's needs. We spoke with 19 members of care staff, seven nurses, three unit managers, the home manager and members of the provider's service recovery team.

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

During our inspection, we shared our concerns about safety at this service with the local authority and local Clinical Commissioning Group. We also made a number of safeguarding referrals to the local safeguarding team and shared our fire safety concerns with the fire service.

Inadequate

Is the service safe?

Our findings

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

We received mixed feedback from people and their relatives with regards to safety at the service. Positive comments from people and their relatives included; "I'm safe here" and, "[Person who used the service] seems to be safe". However, some people and their relatives raised safety concerns with us.

On Wedgwood unit, some people told us that they did not always get their medicines when they needed them. One person told us how concerns about their medicines had made them, "Very anxious". They said, "One night, I asked for pain killers and I was told they hadn't got any. How can that be?" and, "I have [a named health condition] and I need my tablets at set times. I was told not to panic as they had run out of them. Surely they should have realised that they had given me the last one from the pack". Another person told us, "I've been up all night as I haven't had my tablets. I'm in pain". This person was displaying signs of agitation and distress as they were shaking and crying. This person's care records showed and staff confirmed that they had been admitted to the service without one of their prescribed medicines and there had been a delay in requesting this missing medicine. This delay was caused by a member of night staff not raising the missing medicine at the morning handover. This showed that some people experienced anxiety and distress as result of not getting their medicines when they needed them.

We found that medicines were still not managed safely at the service. We identified on-going concerns with medicines ordering, storage, administration and recording. For example, on Wedgwood unit, one person's medicines administration records (MAR) showed they had not received two of their prescribed medicines for a five day period as their stock had ran out. This meant people did not always receive their medicines as prescribed as people's medicines were not always available at the service. On Stafford unit we saw that one person's MAR showed they had taken their prescribed medicines. However, we saw the staff member responsible for administering medicines had left the person in their bedroom unsupervised and had not checked that the person had taken their medicines before signing their MAR. This person's medicines had been hidden in their cup of tea as stated in their care plan which meant there was a risk that their medicines may not have been taken if the cup of tea had been removed by a staff member. It also placed other people at risk of taking medicines that had not been prescribed for them as some people on this unit did move about accessing and entering other people's bedrooms at times.

We found that risks to people's safety were still not always assessed and planned for. For example, on Wade unit we observed and staff told us that one person moved themselves around in a wheelchair that was not designed for this purpose. This posed a risk of injury and harm to the person who used the wheelchair and other people on the unit. No risk assessment had been completed that identified and planned for these risks and there was no reference to the use of the wheelchair in the person's care plan. On Wedgwood unit, we

found that a person's risk of falling had not been appropriately assessed and planned for, despite them being admitted to the unit for a period of rehabilitation following a recent fall. This meant that people were at risk of unsafe care and treatment because the risks associated with care needs had not been appropriately assessed and planned for to promote their health, safety and wellbeing.

Some people who used the service displayed behaviours that challenged, such as verbal or physical aggression. We found that the risks associated with these behaviours continued to not always be assessed and planned for. For example, on Wade unit staff told us and care records showed that a person who used the service was aggressive at times. One staff member said, "[Person who used the service] tried to stab me with a fork once". This person's care records contained no risk assessment that acknowledged the person's behaviours and no plan to guide the staff in how to manage these behaviours. On Wedgwood unit, one person's care records showed they displayed behaviours that challenged which included; entering other people's rooms at night, being verbally abusive to other people and sexually assaulting staff. No risk assessment or plan was in place to guide staff in how to manage these risks and staff we spoke with did not know how to manage these risks effectively and consistently. For example, two staff we spoke with didn't know this person displayed behaviours that challenged. This placed people and staff at risk of harm to their health, safety and wellbeing because behaviours that challenged were not always being assessed, planned for and managed effectively.

Some people and their relatives told us and we saw that care was not always provided in accordance with risk management plans. For example, on Spode unit one relative told us that their relation had not received their care in accordance with their care plan on the morning of the first day of our inspection. They described this as, "Abuse". We checked this person's care records and observed their care and we found that their risk of skin damage and another of their specific health related risks had not been managed as planned. Staff we spoke with who supported this person on the first day of our inspection told us they were not aware of this person's risk management plans relating to their skin and specific health need as they had not read the person's care plans. This meant this person was not consistently supported in a safe manner, placing them at risk of skin damage and other health concerns.

Some people's care plans stated they needed to be supported to change their position on a regular basis to manage their risk of skin damage. On Wedgwood, Wade and Stafford units care records showed that people were not always supported to change their position as often as planned. For example, on Wedgwood unit one person's care records showed gaps of up to 11 hours and 15 minutes. This person's care records also showed that their skin was deteriorating. This meant people's risk of skin damage was not always being managed as planned, placing people at risk of harm to their health, safety and wellbeing.

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

At our last inspection, we told the provider that improvements were needed to ensure staff were deployed effectively to meet people's needs in a prompt manner and to promote people's safety. This was not identified as a regulatory breach at that time. At this inspection, we found that the required improvements had not been made on all units.

People and their relatives gave us mixed feedback about staffing numbers on the units. Feedback regarding staffing numbers on Stafford unit was overwhelmingly positive and included; "I just press [call bell] and they come" and, "They are always around". However, some people who resided on Wedgwood, Spode and Wade units told us that they sometimes experienced significant delays in receiving care. Comments included; "You

can be ringing for ages and nobody comes. The first thing they do is come into your room and turn it [call bell] off, not ask you what you want so you have to keep pressing it" and "The morning is the worst and often I have to wait longer then. I've waited an hour or longer on some occasions". This showed that some people on Wedgwood, Spode and Wade units felt they experienced delays in receiving the care and support they required.

Staff we spoke with on Wedgwood, Spode and Wade units told us that they felt there were not always enough staff available to meet people's needs promptly and safely. Comments from staff included; "We can't always meet people's needs quickly", "We've not got the time or staff to properly support people" and, "There's too many chiefs and not enough Indians". Our observations on Wedgwood unit confirmed that staff were not deployed effectively to meet people's needs in a prompt manner. For example, we saw a person wait 39 minutes to be supported to access the toilet. During this time, the person's behaviours that challenged escalated and they became verbally aggressive towards staff. Another person who used the service responded to this person's aggression by saying, "It's a long time that they've been waiting. They [staff] keep telling them they'll come in a minute. They shouldn't say that if they don't mean it". We also observed another person wait 30 minutes before they were supported to access the toilet. This person called a staff member over after 20 minutes of waiting and said, "Have they forgotten about me?". The staff member responded by telling the person they needed to wait for another staff member to become available to help them to move safely. This meant that we saw that people waited for unacceptable periods of time to be supported with their basic care needs.

On Wedgwood unit, we spoke with three staff who had not received a handover before their shift. Two of these staff were agency/temporary staff who were unable to tell us any information about any of the people they were employed to support. One of these staff members told us they had been asked to supervise the communal lounge and support people to access the toilet. When asked how they would support people to access the toilet this staff member said they would ask the person and just ask them to try and walk first as it was, "A rehab unit". However, some people on the unit couldn't tell staff what support they needed and some people were not safe to walk. The two agency staff members also told us they had not received an induction to explain the service's fire procedures, including the location of fire exits. This placed people at risk of receiving unsafe and unsuitable care, placing them at risk of harm to their health, safety and wellbeing.

Permanent staff we spoke with told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. However, we found that information about the suitability and skill sets of some of the agency staff who were supporting people on Wedgwood unit had not been requested by the provider. This meant that improvements were needed to ensure effective systems were in place to protect people from the risks of receiving care from unsuitable staff.

The provider told us that staffing levels were regularly assessed and reviewed and all units were, "On paper overstaffed". Staff rotas we viewed showed that the provider's assessed staffing levels were mostly met. However, the evidence above shows that staff were not always deployed effectively or suitably informed about people's risks and needs to enable them to provide safe and timely care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were needed to ensure incidents of potential abuse and neglect were reported in a prompt manner in accordance with national and local safeguarding guidance. This was not identified as a regulatory breach at that time. At this inspection, we found that the

required improvements had not been made on all units.

Staff we spoke with told us how they would identify and report potential abuse and neglect. However, we found that incidents of abuse were not always recorded and reported as incidents, so referrals to the local safeguarding team were not always made as required. For example, the care records for a person on Stafford unit showed they had sustained multiple bruises; the causes of these bruises were unknown. The care records of a person from Wedgwood unit showed they had not received some of their prescribed medicines for a five day period. Neither of these incidents had been reported to the local safeguarding team as potential abuse/neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection, we found that professional advice was not always acted upon to promote people's health, safety and wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had not been made on all units.

People and their relatives told us and care records showed that they could access doctors and other health care professionals when they needed to. For example, one relative said, "If I come some mornings and he has a cough they will tell me he is going to see the Doctor. They are spot on with that". However, we found that professional advice was still not always acted upon to promote people's health and wellbeing. For example, one person's care records on Wedgwood unit showed that nurses from the hospital had handed over that this person's wound dressing needed changing every other day. However, their care records showed that their dressings had not been changed for a three day period. Visiting healthcare professionals we spoke with during our inspection raised this as a safety concern as they suspected this person's wound had become infected. The care records of a person who resided on Wade showed that speech and language and medical advice was not always followed to promote their safety. This person had been prescribed a modified diabetic diet. However, care records showed and staff confirmed that this person was supported to eat a specific food that was not safe for them to consume. These examples show that professional advice was not always followed to promote people's health and wellbeing.

On Wedgwood unit, we found that some people's health and wellbeing needs had not been assessed and planned for to ensure staff were aware of how to manage these needs. For example, two people's pre admission assessments showed they had a condition that could result in seizures. However, no assessment of these people's health needs had been completed in relation to this and staff we spoke with were not aware these people had a history of seizures. Another person on this unit had a dressing on their leg that had been in place since the day of their admission to the unit. The person's care records did not contain a wound assessment or care plan and staff we spoke with did not know what was under this person's dressing, even though they had been on the unit for seven days. This meant that there was a risk that these people's health needs would not be monitored or managed effectively and safely, placing them at risk of harm, including injury and infection.

The above evidence shows that effective systems were not in place to ensure people's health and wellbeing needs were assessed, monitored and managed to promote safety. Professional advice was also not always followed to promote people's health and wellbeing. This was an additional and continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we identified gaps in the staffs knowledge and skills. The provider told us they had plans in place to address these gaps. This was not identified as a regulatory breach at that time. At this inspection, staff told us they felt they had the training they needed to provide safe care. However, we found significant training gaps were still present, placing people at risk of receiving unsafe care. For example, on Wedgwood unit we identified and provider audits showed on-going poor quality care planning around

wound/skin care. However, only two of the 11 staff identified as needing skin care training had completed this training and a further two staff members had been booked on to this training. This meant seven of the 11 staff responsible for skin care planning had not received or been booked on to this much needed training. We found that people were receiving unsafe care in relation to their skin due to a lack of quality care planning. For example, one person's wound was not dressed in accordance with professional advice, because this advice had not been incorporated into the person's care plan for the staff to follow. This meant that people were at risk of receiving unsafe and ineffective wound care as the staffs' training needs in this area had not been promptly addressed.

Training records also showed significant gaps in fire safety awareness and fire extinguisher training. For example, records showed that 57 of the 150 staff records we looked at had not completed up to date fire safety training. Three of the staff's records showed they had been overdue this training since 2015. This meant people could not be assured that staff had the up to date knowledge and skills needed to promote their safety in the event of a fire.

The above evidence shows that effective systems were not in place to ensure that staff were suitably skilled to meet people's needs in a safe and effective manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who could tell us about their care told us their consent was sought before staff offered assistance. We saw that this was the case on Wade, Spode and Stafford units. However, some people on Wedgwood unit told us and we saw that care was not always provided in accordance with people's consent. For example, one person told us that some staff didn't always ask them if they wanted support with washing and dressing before they started to provide this support.

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

On Wedgwood unit, we found that people's capacity to make decisions about their care was not always assessed in a timely manner to ensure they consented to their care and to prevent unnecessary restrictions being placed on them. For example, we heard one person ask a nurse if they could keep one of their 'as required' medicines on their person to enable them to take this medicine as and when they required it. This medicine was prescribed to help the person's breathing. The nurse told the person, "I have to take that away. I'll have to speak to the nurse in charge about whether you can keep it". This caused the person distress and they became increasingly agitated. This meant the person's medicine had been taken from them without their consent. Two and a half hours after having this medicine taken from them, the person became very distressed and agitated and staff had to fetch this medicine for them to take to help their breathing which had become erratic. At this time, we saw this person ask another nurse if they could keep this 'as required' medicine. The nurse replied by saying, "We need to complete an assessment before we can do that to make sure you're safe". This nurse told us they would complete this assessment and make a decision about the person's capacity to manage this medicine on their own. This meant this assessment had not been completed in a timely manner which caused the person unnecessary distress and agitation.

Care records on Wedgwood unit often contained gaps around people's capacity to consent to care. For example, the section about people's capacity to consent to their care was often blank on preadmission assessments. Therefore we were not always able to establish if people had consented to their admission to

the unit. We also found that some care records contained conflicting evidence around people's capacity to consent to their care. For example, one person's care records showed they were able to make simple choices and decisions about their care with the support of family and staff. However, their relative had signed a form in their care records consenting to information about the person being shared with other professionals rather than the person in receipt of the care. There was no evidence to show this person had been assessed as not having the capacity to consent to this part of their care.

On Spode unit we identified a person who had a long term health need which we saw and staff confirmed caused the person pain and discomfort. Staff told us this person's relatives had requested that no further action be taken in relation to this health need. Staff were unable to evidence that this decision had been made in the person's best interest under the MCA as at the time our inspection began, this decision had been based around the wishes of the person's relatives rather than with the input of a multidisciplinary team.

The above evidence shows that effective systems were not in place to ensure care was consistently provided with people's consent and in accordance with the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw and care records showed that some people who used the service had some restrictions placed upon them to keep them safe and well. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. On Stafford and Spode units, we saw that restrictions were placed on people in a lawful manner in accordance with the MCA and DoLS. However, on Wade unit we found that a person was being unlawfully restricted as a DoLS request had not been made. This person required constant monitoring by staff of their whereabouts and behaviours. The nurse in charge on Wade at the time of our inspection confirmed that the person had been assessed as not being able to consent to their care, and that a DoLS request had not been made for this person. They felt this could be due to the absence of a ward manager on that unit. This meant that in the absence of a unit manager DoLS referrals were not always being made when required.

On Wedgwood unit, we observed a person ask staff on multiple occasions if they could leave the unit to go to the local shops to purchase some cigarettes. Multiple staff members told the person they couldn't leave the unit, despite the person telling the staff they knew where they were, where the shops were and how to get to the shops safely. On one occasion the person responded to a staff member who told them they couldn't leave by crying and saying, "You are treating me like I don't know what I'm doing". No assessment had been completed to show this person could not leave the unit and no plans were in place justifying this restriction that had been placed upon them. This meant this person had not been protected from the risk of unnecessary control and restraint.

The above evidence shows that effective systems were not in place to ensure people only had restrictions placed on them lawfully to promote their health, safety and wellbeing. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about the food at Stadium Court. Positive comments from people about the food included; "I like the food, I eat what they give me", "Yes, the foods quite good actually, it's improved a lot. When I first came here it didn't seem that good but it seems to be better" and, "I don't really like the food,

sometimes it's cold". Most people told us that they were often given choices at mealtimes. Comments from people around meal choices included; "They do give choice" and, "Just before we have meal they ask would you like 'this' or 'that'?". However, we saw that people were not always given the information they needed to make informed meal choices. For example, on Wedgwood unit people were offered fish or mince. One person asked staff, "What sort of fish?" and the staff member replied, "Breaded fish". The person then replied, "Yes, but what sort of fish?" and the staff member responded again by saying, "It's breaded". The person then stopped asking the staff member for more information and made their meal choice based on the limited information they had been given.

Inadequate

Is the service caring?

Our findings

At our last inspection we told the provider that improvements were needed to ensure people were consistently treated with dignity. This was not identified as a regulatory breach at that time. At this inspection, we found the required improvements had been made on Stafford unit, but they had not been made and sustained on Wedgwood, Wade and Spode units.

Some people told us and we saw that staff did not always respond in a caring manner when they requested support. For example, one person on Wedgwood unit told us how they felt when staff repeatedly asked them to wait. They said, "When they say, 'wait a minute', 'wait a minute' all the time it makes people feel disrespected and unimportant". Another person on this unit told us, "I don't want to live another day". This was after they had been heard shouting for support from their bedroom to go to the toilet for a period of at least 15 minutes before a staff member acknowledged their shouts. We saw two staff members walk past the person's room during this 15 minute period who did not respond to the person's shouts.

We also saw that staff did not always respond to people's signs of distress and agitation in a caring manner. For example, on Wedgwood unit we saw a person in the communal lounge where staff were present stating they were hallucinating. This person was visibly distressed and agitated as they were shaking and repeatedly seeking assurances from our inspection team. A staff member only came over to the person when they started to cry. This meant the person had not been supported when they first displayed signed of distress and agitation. This led to them become upset in a communal area in front of other people who used the service. On Spode unit, we saw that a person was visibility distressed and agitated in a communal area for a period of three hours. The person was hitting and scratching their head and were rubbing their back against their chair. This person's relative told us the person was behaving in this way as their skin was itching. The person's care records showed and staff confirmed that they had not received their prescribed medicine to help their skin condition. Staff only intervened to apply this person's prescribed cream when we highlighted this to them. This meant the staff had not promptly responded to this person's signs of agitation and distress.

We saw that people were not consistently involved in making day to day choices about their care. For example on Wade unit at breakfast we saw one staff member asking people if they would like their hands wiped before their meal. This staff member waited for people to respond before they provided this support. However, we saw another staff member at the same time, putting aprons over people without asking them if they wanted to wear an apron. On the same unit, we saw a staff member go to the TV which a person was sat watching. The staff member turned the TV off and put the radio on without asking the person if they minded the TV being turned off.

We also saw that people were not consistently supported to understand the choices available to them to help them make informed choices. For example, on Wade unit we saw a staff member show a person the choices available to them for breakfast to help the person decide. However, on Spode unit we saw staff only offered people meal choices verbally which did not help people who struggled to process verbal information to make informed meal choices.

On Wedgwood unit most people told us and we saw that staff did not have a good understanding of them or their needs. One person told us and we saw that some staff had been calling them by the wrong Christian name. They said, "It's been happening to me the last couple of weeks. I've just blocked it out". Some staff that we spoke with, in particular the agency staff on this unit were unable to tell us basic information about people, such as their names and how they needed to be supported to move around the unit. For example, when we asked one agency carer how they would know how to support people to move they said, "I just watch and see how they manage". This staff member also told us they had supported three people to get washed and dressed, but they were unable to tell us the names of the people they had spent time supporting. Permanent staff told us that they had been unable to get to know newly admitted people on the unit as there had been a very high number of admissions over a short period of time. Comments from staff included, "Agency staff always come to us and ask us who residents are, but we are not always 100 percent sure" and, "It's ridiculous. How are we supposed to know all the residents?". This meant people on this unit were not always supported in a caring manner as staff did not always have a good understanding of their care needs and preferences.

The above evidence shows that people were not consistently treated in a manner that promoted their dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, we received mixed feedback from people and their relatives about the attitudes and characteristics of the staff. Comments included; "They're all lovely", "They seem to love her" and, "Some of them go out of their way to help resident's others just do the basics." This showed people's experiences of receiving care from the staff at Stadium Court were inconsistent.

People and their relatives told us that staff knew people's likes, dislikes and care preferences on Stafford, Spode and Wade units. For example, one relative on Wade unit said, "They [the staff] know [person who used the service] well". We saw also saw that most staff on these units knew people's likes, dislikes and care preferences. For example, on Stafford unit we saw a staff member support a person to locate some items that were important to them from their bedroom. This person then showed other people these items and they became a talking point for people and staff.

People told us and we saw they could access private areas of the home to speak with visiting healthcare professionals and relatives. One person said, "I can go to my bedroom with my visitors". A relative told us that their relation was happy sitting in the communal areas with visitors. However, they said, "We could go to their bedroom if needed".

Inadequate

Is the service responsive?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people received care that met their personal preferences and needs. This was not identified as a regulatory breach at that time. At this inspection, we found the required improvements had been made on Stafford unit, but they had not been made and sustained on Wedgwood, Wade and Spode units.

We found evidence that people and their relatives had been involved in the assessment and planning of care on Stafford, Wade and Spode units. However, some people on Wedgwood unit told us they had not been involved in this process. For example, we asked one person if we could look at their care plan that was stored in their bedroom. They said, "Is that what it is. I wondered what it was, people keep coming in and taking it away". This person also said, "I don't even know why I've come here, I've been moved around so much". They also confirmed they had not been involved in the planning of their care and their care records did not evidence any involvement. Another person said, "I wasn't involved with my care plan. I read it with my family and said it was the biggest load of rubbish I have ever read" and, "It said I had no faith, but I do. I had communion three times when I was in hospital, but not here". This meant that this person's faith needs had not being met as staff had not involved the person in the assessment and planning of their care needs.

We also saw that staff on Wedgwood unit wrote people's care plans without involving people. For example, we saw a senior carer and a nurse sitting in the office writing care plans for newly admitted people without those people being present. They told us they were using people's preadmission assessments (an assessment completed by the unit manager prior to people's admission to the unit) to formulate people's care plans. This meant that any changes in care preferences or needs since the preadmission assessment had been completed would not be identified and incorporated into people's care plans. Therefore people were at risk of receiving unsuitable and unsafe care that did not meet their individual preferences.

On Spode and Wedgwood units we saw that staff did not always understand the need to prioritise and act upon people's requests for support. For example, on Spode unit we went into a person's room after we had heard them tapping their table to seek staff support for a 30 minute period. The person told us and we saw that they needed support with their continence needs. We found and asked a member of staff if they could assist the person and they replied, "I have a dirty room to clean first". Fortunately, a nurse on the unit overheard the staff member's response and they instructed them to support the person with their continence needs before they started their cleaning task. This showed the staff member thought it was appropriate to complete a cleaning task before they supported a person with their continence needs. At 12pm on Wedgwood unit we heard a person shout, "Can you come for me please, I just want to go for my dinner" from their bedroom. A cleaner responded by saying, "Well, it's not time yet, they'll come for you when it's time. Why don't you watch the TV?". This meant the cleaner did not pass on the person's request for support to a member of care staff resulting in their request to move to the communal area was not met.

On Wedgwood unit, we found that staff did not always respond to people's individual care requests and needs in a prompt manner. For example, on the first day of our inspection, a person who resided on Wedgwood unit told us they needed a cigarette. They also told us they didn't have any cigarettes on them,

but they had the funds to purchase some. We heard them tell staff this on multiple occasions and staff responded by saying they couldn't take the person out to purchase any cigarettes. We saw that this person became increasingly agitated and distressed throughout the first day of our inspection. Signs of their agitation and distress included; shaking and crying. We raised this issue with staff on the unit at approximately 12pm. The person approached us again at approximately 3:00 pm and told us they still had not had a cigarette. They said, "They've said they can't take me out, so I'm stuck". We asked staff if they had planned to assist this person to purchase some cigarettes and we were told they were looking into it. At 4:00 pm a staff member told us some cigarettes had been purchased for the person. This meant there was a significant delay in ensuring this person's need to smoke was addressed. This delay caused the person unnecessary agitation and distress.

On Wade and Wedgwood units, some people's care records showed and staff confirmed that they could display behaviours that challenged in the form of aggression. We found that detailed plans were not always in place for the staff to follow to ensure people's behaviours were managed in a consistent and effective manner. For example, on Wade unit a person's care records showed and staff told us they could become aggressive at times. We asked staff how they reassured the person and we were given different answers. This meant staff did not always have access to the information needed to provide people with consistent care that met their individual needs.

We saw that people were supported to participate in some organised social and leisure based activities at the service. For example, we saw people participating in quizzes, crafts and singing and we also saw that some people were supported to access outside spaces at the service. However, we received mixed feedback from people and their relatives on all units about the support they received to engage in activities that were important and meaningful to them. Comments included; "They've offered me some activities, but they're not very interesting", "I used to do everything; knitting, sewing, crocheting and now I do nothing" and, "They try their best I suppose, but they're not really for me". This meant some people felt that they were not supported to engage in activities that were meaningful and important to them.

The above evidence shows that people were not always supported to receive their care and support in line with their personal preferences and needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives told us they knew how to complain about the care. For example, one person said, "I would see the manager here and ring CQC if I had to". A relative said, "Yes, I'm very vocal. Oh yes, I know the procedure". We also heard examples from people and relatives on Wade, Spode and Stafford units about how improvements had been made a result of making a complaint. For example, one relative told us they had complained about the state of the bedding and the malodour on the unit. They said, "Everything has been addressed for quite a few months now. Things have changed a lot". Records showed that written complaints were investigated and acted upon appropriately and in line with the provider's complaints procedure. This procedure was clearly displayed on all units at the service.

However, some people and their relatives on Wedgwood unit told us that their complaints were not always listened to or acted upon. People told us these complaints had been made verbally to staff. One person told us that they had complained about people being left waiting for support after meal times. They said, "I made a suggestion that they clear the dining room before they go on their breaks to make sure everyone is okay. It fell on deaf ears. They go on breaks when people are waiting for help". A relative also told us that they had complained about how their relation was dressed. They said, "[Person who used the service] is still not appropriately dressed the way they like for this time of year and we keep mentioning it and nothings been done". We found no written record of these complaints in the unit's complaints log. This meant that

verbal complaints on this unit were not always being recorded to ensure they were managed in accordance with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

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

There was a newly appointed home manager at the service and all units had an assigned unit manager with the exception of Wade unit. The provider's service recovery team were also regularly present on site. However, with the exception of Stafford unit, most of the people and relatives we spoke with were unsure of the management structure at the service. Comments included; "I haven't got a clue, that's something I've asked. There seems to be several managers.", "Who is the manager?" and, "I don't think the manager is around at the moment". This meant some people and their relatives did not know who was responsible for the day to day management of the service.

Effective systems were still not in place to ensure risks to people's health, safety and wellbeing were consistently assessed, recorded, planned for and managed. For example, on Wedgwood unit we saw that a person had been admitted to the unit for rehabilitation following a recent fall. However, this person's risk of falling had not been assessed and planned for. At least two other people's pre admission assessments on Wedgwood unit showed they had a condition that could result in seizures. However, no assessment of these people's health needs had been completed in relation to this and staff we spoke with were not aware that these people had a history of seizures. This meant that risks to people's health, safety and wellbeing were not always being assessed and planned for to promote safety. The provider's quality monitoring systems had not identified these issues as areas of concern, so these issue had not been addressed in order to promote people's safety at the service.

We found that safety incidents were not always recorded and reported by staff to enable the provider to promote people's safety. For example, we saw incidents in people's daily care records on Stafford and Wedgwood that should have been considered as potential abuse and neglect; such as unexplained bruising and medicines errors. However, these incidents had not been recorded on the provider's incident forms so the provider was not aware that these incidents had occurred. One staff member told us, "The seniors fill in those forms, not us". This meant the systems in place to record and report safety incidents were not effective.

We found that the systems in place to monitor and improve safety and quality at the service were not effective. For example, a daily walk around record completed eight days prior to our inspection showed that a person's behaviours that challenged needed to be recorded on a behavioural monitoring form. This person's care records showed that during this eight day period they displayed behaviours that challenged in the form of shouting and being verbally aggressive towards other people and staff, sexually assaulting staff and entering other people's bedrooms at night. None of these behaviours had been recorded on the monitoring chart as identified during the daily walk around. This showed that action was not always taken in

response to feedback from monitoring systems.

Weekly clinical risk meetings had identified concerns with wound care planning and management since at least the beginning of August 2017. For example, it had been identified that wound photos were not always being taken to enable staff to assess and monitor people's wounds. We saw that effective action had not been taken to address this issue as it was on-going. For example, on Wedgwood unit three people's wound care plans showed that regular photos of the wounds were required. However, no photos were contained in their care records as planned. We asked staff where these photos were and we were told, "If they are not in there, they haven't been taken". This meant effective action was not always taken by the provider in response to the identification of concerns that related to the quality of care.

We found that care plan audits identified areas for improvement for individual people. These specific areas were acted upon for those people. However, these audits did not always trigger changes and improvements for other people when needed. For example, a care plan audit on Wedgwood unit showed that a person's mental capacity had not been assessed. This was addressed for this person. However, we found that this had not triggered any checks to be made to ensure other people's mental capacity had been assessed as required. We found that care records on Wedgwood unit often contained gaps around people's capacity to consent to care. For example, the section about people's capacity to consent to their care was often blank on preadmission assessments. This meant that the learning from individual care plan audits were not applied across that unit to ensure people received effective care and support.

The service had a home improvement plan in place in response to the concerns shared at our previous inspection. This action contained detailed information about how the required improvements were to be made and sustained. We found that this plan had not always led to the required improvements being made and sustained. For example, the plan stated how the provider would ensure people's medicines were available for safe administration. However, we found multiple examples of people's medicines being unavailable as they were out of stock. This showed effective action had not been taken to address this safety concern, placing people at risk of harm to their health, safety and wellbeing.

Although records showed that individual written complaints were responded to in line with the provider's complaints policy, we found that effective systems were not in place to ensure learning from complaints was shared to prevent similar themed issues from occurring. For example, we saw one complainant had raised concerns about the knowledge and skills of agency staff. The written response from the provider stated, 'I can confirm that prior to an agency staff member commencing work in any of our care homes, they receive and induction into the home which includes fire evacuation'. We found that this was not always the case as some agency staff we spoke with on Wedgwood unit told us they had not received and induction of any kind. This showed that effective action had not been taken to ensure that learning from complaints was applied to prevent similar issues from reoccurring.

We also saw that effective action had not been taken in response to the findings of a recent fire and rescue service visit in July 2017. The provider had been served a notification of fire deficiencies that identified that agency staff were not always receiving a fire safety induction. As recorded above, some agency staff we spoke with told us they had not received an induction that covered fire safety at the service. This meant the provider had not taken action in response to their fire safety regulatory breach. This placed people at serious risk of harm to their health, safety and wellbeing.

Records showed that Stafford, Spode and Wade units held occasional meetings with people and their relatives to seek feedback about the quality of care. We saw that feedback from these meetings was listened to and acted upon. For example, people had asked for improvements to be made to ensure people could

access outside space that was sheltered. We saw this had been acted upon and we observed people sitting under a sheltered area outside of their units. However, people told us and staff confirmed that these meetings were not held on Wedgwood unit. People told us their feedback about their care was not sought by the staff. Comments from people included; "They've not asked me about the food or what I'd like to see on the menu" and, "I haven't had a say in the activities that go on". This showed that feedback from people who resided on Wedgwood unit was not sought in the same manner that it was for other people who used the service. This meant that people on Wedgwood did not have the same opportunities to share their thoughts and ideas about their care.

We received mixed feedback from staff across the service regarding the support they received from the management team and their effectiveness. Some staff told us that managers were supportive. For example, one staff member told us how the management team had supported them to attend college by planning their shifts around their college timetable. Some staff also told us the management team were effective in making improvements. For example, one staff member said, "We need more permanent staff, but I think they are trying to get more". However, some staff told us that improvements were needed to the way they were supported and to the way the service was managed. Comments included; "At the moment there's no unit manager or deputy. We need a leader", "I don't know who my line manager is, but I can go to the home manager" and, "I think the management team needs to be more hands on. They don't know what goes on". This meant that some staff felt improvements were needed to the way they and the service were managed.

Some staff told us they participated in group supervision (a method of supporting staff and assessing and managing competencies) with other staff. For example, one staff member said, "I've just had a group supervision with the unit manager. I haven't had a one to one supervision for about two or three years". However, some staff told us they didn't have regular supervision and/or that supervision was not always effective. Comments included; "I get no supervision", "I've never had supervision here, but I do get asked if I'm okay" and, "If you get supervision it's negative, telling you what you are not doing". This meant some staff didn't feel that they received the right support to enable them to work effectively.

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