Stretton Care Limited

Stretton Nursing Home

Inspection report

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24 January 2018

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

Summary of findings

Overall summary

The inspection took place on 19, 21, 23 and 24 January 2018 and was unannounced.

Stretton Nursing Home is located in Hereford, Herefordshire and is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 provides accommodation and nursing care for up to 50 older people. On the day of our inspection, there were 41 people living at the home. This included a number of people who lived with dementia.

At our previous inspection in October 2017, we identified breaches of regulation. These were in relation to staffing, governance, protecting service users from abuse or improper treatment, and notification of incidents. The provider was asked to complete an action plan to set out how they would comply with the regulations.

At this inspection, we found the provider remained in breach of these regulations. We also identified further breaches of regulation. These were in relation to person-centred care; need for consent; safe care and treatment; and meeting nutrition and hydration needs.

The overall rating for this service is "Inadequate" and the service is therefore in "special measures". 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.

There was a registered manager at this home, but they had been absent from work for a period of four months. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered providers and registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels had not been determined according to the assessed needs of people living at the home, which meant there were not enough staff to care for people safely. The lack of staff had an adverse effect on people's personal care needs, hydration and emotional wellbeing.

Systems and processes in place to protect people from abuse were not always followed. Action had not been taken by the provider to address failures to report alleged abuse or harm.

People did not always receive their medicines in accordance with updated instructions from the prescriber. Medicines were not always signed for, which made it difficult to tell whether prescribed creams or liquid medicine had been administered correctly.

Risk assessments were not in place for specific health conditions and infection control. The lack of clear guidance about how to keep people safe placed people at risk of harm

Decisions made on behalf of people who lacked capacity were not always the least restrictive, nor had they been made in accordance with the Mental Capacity Act.

People did not always have enough to drink, even when they expressed symptoms of dehydration. Staff did not always have time to spend with people to encourage them to eat, which placed people at risk of malnutrition.

Staff did not receive sufficient training and supervision to enable them to be effective in their roles. New staff did not have a structured induction before caring for people.

Due to the time constraints staff were under, people were sometimes placed in undignified situations and did not have their personal and continence care needs met in a timely way. People's choices about how they wanted to be cared for were not always taken into account. Staff were unable to spend quality time with people.

People's call bells did not always work, nor were they always kept within people's reach. This meant people could not always alert staff, when needed. People's requests for help were not always responded to.

People's care plans were not reflective of their current healthcare and wellbeing needs, and they sometimes contained incorrect information which then affected the care and treatment people received.

Key information about the service, such as service user guides and complaints procedures, were not in accessible formats for people with physical impairments and disabilities.

There was a lack of clinical and general management of the home, which affected the quality and safety of care provided. Quality assurance measures were not effective in identifying risks to people's health and wellbeing, nor in identifying shortfalls in the service. Where care records were completed, these were not audited or reviewed.

Morale was low amongst the staff team, and they did not feel valued in their roles. Staff consistently expressed concern about unsafe working practices within the home and the pressures they were under.

The provider told us they recognised significant improvements were needed to the quality and safety of care people received, and that they were committed to working in partnership with other agencies to achieve this. During and immediately after our inspection, the provider sought advice from another local provider and asked them to support them in a mentoring capacity. This arrangement is now in place. The provider also implemented the urgent recommendations from the Local Authority and the Clinical Commissioning Group, who are working closely with the provider to bring about improvements. The provider told us that an acting manager was due to start working at the home on 29 January 2018; they are now in post. The provider has implemented a stop on further admissions to the home along with a formal placement stop by Commissioners until improvements are made.

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.

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.

Staffing levels were not sufficient to meet people's needs. People were not protected from the risk of infection.

Important changes to people's medicines were not always communicated and shared, resulting in medicine not being given in accordance with prescriber's instructions.

Risk assessments were incomplete, or not in place at all, which meant there was no clear guidance for staff on how to safely care for people.

Is the service effective?

Inadequate

The service was not effective.

People were placed at risk of dehydration and malnutrition. The principles of the Mental Capacity Act had not been followed, with the least restrictive option not explored for people.

Staff did not receive structured inductions to enable them to care for people effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People were sometimes placed in undignified situations and did not always have their personal care needs met promptly.

People did not always have choices in terms of how they were cared for.

Staff knew people well as individuals and demonstrated a respectful approach towards them.

Is the service responsive?

Inadequate

The service was not responsive.

People could not always alert staff to their need for help as their call bell was broken or out of reach.

Care plans were not reflective of people's current needs, which placed people at risk of not having their needs met appropriately. People's changing wellbeing needs were not always responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The systems used to monitor risks to people were ineffective. There was a lack of oversight and clinical leadership at the home, which affected the quality and safety of the care people received.

Staff did not feel valued or supported in their roles.

Stretton 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.

The inspection was prompted by an on-going police investigation into allegations of abuse at the home. We needed to assess whether people living at the home were at immediate risk of harm and abuse.

This inspection took place on 19, 21, 23 and 24 January 2018 and was unannounced. Days one, two and three were conducted by two Inspectors. Day four was conducted by one Inspector.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service.

We contacted the Local Authority before our inspection visits and asked them if they had any information to share with us about the care provided to people. We have continued to liaise with the Local Authority and Clinical Commissioning Group throughout the inspection process.

We observed how staff supported people. As part of our observations, 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 spoke with seven people who lived at the home. We spoke with the registered provider; three nurses; an agency nurse; six care staff; an agency care worker; the administrator; the housekeeper; an activities coordinator and the newly-appointed clinical lead. We also spoke with a visiting social worker; a Clinical Commissioning Group nurse specialist and an advanced practitioner from the district nursing team.

We looked at twelve care plans; three staff recruitment records; daily fluid records and associated care records; medication administration records; the provider's safeguarding and whistle-blowing policies;

records; and an incident report.

Inadequate

Is the service safe?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not fully understand and fulfil their individual responsibilities to prevent, identify and report abuse.

Shortly prior to this inspection visit, the police were leading an investigation into allegations of abuse involving a number of people who used the service. The allegations related to a time period of the past two years. This investigation was on-going and had identified that some staff members had not followed the provider's policies and procedures for disclosing and reporting incidents they may have witnessed in order to safeguarding people who use the service. In addition, we found that the provider had not followed their staff disciplinary policy in relation to actions taken regarding staff who had failed to report incidents. This had placed people at risk of being cared for by staff members who did not safeguard them from abuse or improper treatment. On day two of our inspection, the provider had taken the necessary immediate action in relation to staff members to reduce the risk to ensure people's safety.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not always deploy suitable numbers of staff to make sure people's care and treatment needs were met. The provider was asked to complete an action plan, setting out how this regulation would be met. Their action plan told us they had recruited a deputy manager, a registered nurse and five care workers since the inspection. They also told us there would be "regular checks on staffing levels."

At this inspection, we found the provider remained in breach of this regulation. There was no dependency tool in place to determine the necessary staffing levels to meet people's current clinical and care needs. On day one of our inspection, people and staff told us, and we observed, staffing levels were insufficient to meet people's needs. One person we spoke with told us, "Everyone (staff) is like a bumble bee. Here, there and everywhere. If I ask them to move me, they can't as they are off somewhere else." Another person was shouting out, "Nurse, nurse!" from their bed. We were unable to find a member of staff to assist, and the person became increasingly distressed because they told us they had needed assistance to go to the bathroom, but there had been no one to help. Staff showed visible signs of distress to us about not being able to meet people's needs. One member of staff told us, "I get stressed. You don't feel you're getting anywhere, yet you never stop. We struggle to give drinks out, and sometimes we are still washing people at 5.30pm in the evening." Another member of staff told us, "People's needs have changed, but staffing levels have stayed the same. By the time you've done your turns and skin checks, it is time to go again. Yet we are also meant to somehow fit in getting people up, washed and dressed." We observed that in the morning, there were two people up and dressed. Staff told us there was no time to get people up until the afternoon; we saw more people up and dressed at lunchtime. This meant some people had to wait until the afternoon before they could get up.

We spoke with the provider about these concerns, who confirmed there was no dependency tool in place and there was no rationale for the current staffing levels, other than they had always been at that level. In response to this, the provider increased staffing levels with immediate effect, from four care workers on each side of the home to five. By the end of our inspection, the provider increased this again to six, after conversations with staff. We spoke with staff after these changes had been made, and they told us it had eased the pressure and had meant people had received the care they needed. One carer told us, "Everyone has been able to have a bath today, which is amazing. They normally have about one a week." We observed this increase in staffing levels meant that staff had more time to assist people, and that people did not have to wait as long for help when they requested this. After our inspection, the provider introduced a dependency tool to ascertain people's current care and support needs and the commensurate amount of staff needed to safely meet these needs. Although the provider took immediate action to increase the staffing levels during our inspection, they had not reviewed the staffing levels since the previous inspection and taken steps to increase the staffing ratios in line with people's care and dependency needs.

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

We considered how staff were recruited, and whether safe recruitment practices were in place. The provider had ensured that staff had gone through checks with the Disclosure and Barring Service before they started work at the home. The purpose of these pre-employment checks is to prevent unsuitable staff from caring for people who use the service. However, where applicants had gaps in their employment history, there was no evidence to demonstrate the provider had sought more information from the applicants. It is good practice for providers to ensure they explore employment gaps with prospective members of staff. We also saw the provider's own interviewing scoring system had not been followed, with partly complete score sheets in place for some recently-appointed members of staff. We asked the provider about this system, and they told us it had not been relied upon when interviewing prospective members of staff. They were unable to explain to us how they were assured the applicants had met the essential criteria for the role.

At our previous inspection, we found that risk assessments did not always clearly set out how to meet people's individual care and support needs and keep them safe. At this inspection, we found risk assessments remained incomplete and in some instances, did not exist. For example, out of a sample of four epilepsy care plans we looked at, none contained important information about people's individual triggers, types of epilepsy, nor the signs and symptoms to be vigilant to of a sign of a seizure of absence. One person's assessment said, "Attacks x2", but there were no other details provided as to what this meant, when the 'attacks' had happened, and what had been done to keep the person safe. Care and nursing staff we spoke with gave conflicting accounts about people's epilepsy and, in the absence of risk assessments and specific care plans, we could not be assured that staff knew how to keep people with this condition safe.

Where people were at risk of pressure sores, this was clearly set out in their care plans and their Waterlow assessment scores were reviewed monthly. However, there was no repositioning guidance in place for staff to follow to enable them to know how often to support the person to change their position . One person had a Grade 3 pressure sore, but their care plan did not set out how often they needed to be repositioned throughout the day. The provider told us this person had capacity and chose to refuse pressure care, but there was no behavioural support plan or risk assessment in place regarding this, nor was there any evidence to suggest the risks of refusing pressure care had been explained to them. Photographic evidence of the wound in the person's care plan showed a deterioration in the person's pressure sore in the last month, which was confirmed to us by a visiting health professional. By failing to support this person with their pressure care needs, their skin health had suffered as a result. We also found that another person's Waterlow score showed the person's risk of pressure sores had increased from high risk to extreme risk over

the last month. There was no repositioning guidance in place for this person, nor any record of daily skin checks.

Another person was assessed as being at high risk of pressure sores. Their repositioning chart showed they had been left in the same position throughout the day for nine hours, yet had been woken up throughout the night to be repositioned. Staff we spoke with could not explain what the rationale for this was, nor did they know how often the person should be turned to maintain their skin integrity. This person had been left in the same incontinence pad for 11 hours, which could have compromised their skin health further.

As a result of these concerns, the Clinical Commissioning Group arranged for clinical support and guidance for the provider in regard to pressure care. This included raising staff awareness; reviewing people's pressure relieving equipment; and ensuring there was clear repositioning guidance in place for staff to follow.

There were also no risk assessments in place regarding infection control. For example, one person had a contagious bacterial infection. There was no risk assessment or care plan in place regarding how to keep this person, and other people, safe. On the first day of our inspection, a member of staff told us the person had an infection and that they had to stay in their room; there was no signage on the person's door to alert people to an infection control issue. However, on the second day of our inspection, this person was sitting in a communal area. We asked a different member of staff why that was, and they told us the person did not like staying in their room. No one was able to tell us whether the person had to stay in their room, whether the person was a carrier of the infection, or whether it was safe for them to be with other people who lived in the home. Care and nursing staff did not know the procedures in place to prevent the risk of infection. One member of staff told us, "I came in, being new to care, and they just said 'always have an apron on.' I went home and found out about (the infection) myself." Another member of staff told us, "I just work on the basis now that [person's name] has (the infection) because I know it comes and goes. We never get told, so I just assume they have it." A visiting clinician from the Clinical Commissioning Group (CCG) directed the provider to arrange for an up-to-date swab from the person to test for infection, as this had not been done for over three months, and for barrier nursing to be put in place. The provider arranged this with immediate effect. However, this was at the request of visiting health professionals, and was not something they had identified themselves as being a risk.

Whilst staff expressed concern to us about how infection control was managed, they mentioned two further individuals, one of whom was believed to have a blood-borne virus, and another who was believed to have a skin infestation. Staff we spoke with gave us different answers as to what strain of virus the person had. Whilst the person's care plan made reference to the virus, there was no risk assessment in place, or condition-specific care plan about how to meet the person's needs. One member of staff expressed concern because they had not known of the person's virus, and the person had caused a wound to the staff member's arm, using their bloodied fingernails. This member of staff had continued to provide personal care to people. We raised this with the provider and the commissioners as an immediate concern.

As staff had been unaware of the person's skin infestation, they had not followed infection control guidance and had done things such as placed the person's laundry in with the usual laundry, rather than using designated red bags to keep it separate. This placed people and staff at risk of infection, with one member of staff being absent from work as they too now had the same skin condition.

As a result of these concerns, the CCG arranged for the infection control and prevention team to visit the home and carry out an infection control audit, as well as for them to provide training and guidance to the staff and to the provider regarding the importance of infection control and prevention.

We looked at whether people received their medicines safely and as prescribed. Not all medicines had been signed for, with there being gaps in the medication administration records (MARs). Where the medicines not signed for were in tablet form, we were able to check the stock-count of these and were assured these had been given, but not signed for. Failing to sign for medicines is contrary to the safe administration of medicines, as it could result in a person being given a double-dose of the medicine. However, where eye drops and prescribed creams had not been signed for, there was no mechanism to be able to check these had been given due to the nature of their form. Where there had been changes to the prescriber's guidance on how a medicine should be administered, this was not always documented and communicated. One person was prescribed a non-benzodiazepine hypnotic agent. Their GP had reviewed them on 12 January 2018, and advised this medicine was now to be given on an 'as required basis' only; not every night. Because the person's MAR had not been updated, we saw that staff had continued to administer this medicine to the person on a nightly basis. Care staff expressed concern to us that the person was drowsy and unresponsive during the day, which is a recognised side-effect of this medicine. We discussed this with a member of the nursing staff team, who updated the person's MAR and said they would make sure all nursing stuff, including agency staff, were made aware of this change. By not ensuring the person's MAR had been updated, this had placed the person at risk of being given sedative medicine they did not require.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our previous inspection, we found that the principles of the Mental Capacity Act 2005 had not always been adhered to, specifically in relation to best interest decision- making. 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection, we found the best interest decision-making process had not been followed where decisions had been made about people's care and support. For example, one person was cared for in bed. We looked at the clinical rationale for this, and found a moving and handling risk assessment in the person's care plan, which said the person did not like being hoisted and so was "bed bound." Whilst there was a written record in the person's file to say this decision had been made in the person's best interest, this decision had been made in isolation by a nurse at the home. Best interest decisions should involve other health professionals, family members and advocates, where applicable. This decision had not been reviewed, nor had the least restrictive option been considered. For example, no consideration had been given as to what the person disliked about being hoisted; whether other moving and handling techniques could be used; or whether the person responded differently to different members of staff. By failing to adhere to the principles of the MCA, this placed people at risk of unnecessary restrictions. We reviewed three care plans of people who were nursed in bed due to being "frail", and found the principles of the MCA had also not been followed, which potentially meant people had been restricted unnecessarily.

We also found contradictory and unclear recording about people's capacity and ability to consent. One person's care plan simply stated, "[Person's name] lacks capacity to make appropriate decisions." There was no decision-specific information about what decisions the person was unable to make. One person's care plan contained contradictory information about their wishes regarding cardiopulmonary resuscitation. The plan stated the person had capacity and did not wish to be resuscitated in the event of cardiac failure. However, the person's advanced care plan stated the person wished to be resuscitated. Such conflicting information meant it was not clear what the person's exact wishes were, which placed the person at risk of not having their preferred course of action adhered to.

This was a breach of Regulation 11 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

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 provider was working within the principles of the MCA. Since our previous inspection, there had been a review of people's DoLS authorisations to make sure these had not expired and that people were not being unlawfully deprived of their liberty. Out of sample of four DoLS authorisations we looked at, we found the provider was complying with the conditions set out in the in DoLS and that authorisations had not expired. During the course of our

inspection, a consultant psychiatrist visited the home to take part in a DoLS review for a person living at the home, which demonstrated reviews were taking place with relevant health professionals. However, we were concerned by staff's lack of awareness of who had a DoLS in place. One member of staff told us, " I don't know; we're not told." Another member of staff told us, " You'd think we'd all be told about important things like that, but we haven't been." It is important that staff have an understanding of who is being deprived of their liberty and why, and what those restrictions mean for staff's practice. This concern was raised with the provider during the course of our inspection.

We looked at whether people had enough to eat and drink. During the course of our inspection, we observed that drinks were left out of reach for people and that a significant number of people were unable to drink without staff assistance. We were particularly concerned about the hydration needs of the people living on the Woodlands side of the home, as this was the unit where staff were particularly short-staffed, and also where people with the most complex healthcare needs lived. A nurse working on the Woodlands told us that 10 people were at risk of dehydration. We looked at a sample of these 10 people's fluid intakes over a course of a few days. One person had reported symptoms of dehydration (sore and dry mouth; cracked lips) to night staff on 21 January 2018. This person's care notes recorded they had drank a total of 430 ml that day, and had been offered 800ml. Night staff documented they had "pushed" fluids. However, the records show the person was not given fluids at 7.55 pm; 9.50 pm; 11.50 am; 2 am; and 5 am, with fluids only being given at 12.30am and then again at 8.20 am.

Out of a sample of four fluid records we looked at of people who were assessed as being at risk of dehydration, their daily fluid intake did not exceed 600ml a day. Staff confirmed with us that due to time constraints and the complex needs of people living at the home, people were not having their hydration needs met. We raised this with the provider as an immediate concern, who told us housekeeping staff would be deployed to assist with drinks rounds to make sure people were given enough to drink. However, because no one had individual fluid targets in place based on their weight and healthcare needs, there was no way of ensuring people's individual hydration needs were met. Due to the serious nature of this concern, the CCG arranged to support the provider in ensuring individual fluid targets were in place and in educating the staff about the importance of hydration and ways to encourage and support people to drink. This action was completed immediately.

On the first couple of days of our inspection, although we saw staff assisted some people to eat their meals, where required, we also saw that where staff were not available to assist and encourage people, meals were left to go cold and were therefore no longer appetising. Staff told us they struggled to provide support to everyone who needed this. On day four of our inspection, an activities coordinator was helping people to eat. They explained to us they "helped out" because there was not always enough staff to spend time with people. A nurse we spoke with told us, "I very rarely get to go home on time as I stay and help with the meals. I don't get paid for it, but I can't just go home thinking that people might be hungry." At the time of our inspection, we checked weight loss records and found that no one had lost any significant amount of weight over the last six months. However, there were people who had a low Body Mass Index (BMI) and their Malnutrition Universal Screening Tools (MUST) demonstrated they were at risk of malnutrition. By not having time to assist people with eating, this placed people at risk of weight loss and malnutrition.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, staff expressed concern over the lack of induction, training and guidance in their roles. At this inspection, staff continued to express concerns of this nature. One member of staff told us, "My induction was simply work alongside an existing member of staff for two shifts, then away you go. No

wonder so many new staff leave after a week or two; they are not prepared for the role." Another member of staff told us, "I did get thrown in at the deep end. " A third member of staff told us they had received useful training in their role when they started regarding the use of thickeners for people's drinks. However, we found that a tub of thickener was left on the floor in one person's room and was within their reach. NHS England issued a patient safety alert in February 2015 regarding appropriate storage of thickeners. Specifically, they should be stored securely so that people cannot swallow the product and be placed at risk of asphyxiation. Staff were not aware of this guidance, which raised concerns about the extent of the training they had received in this regard.

Staff also expressed concern over the on-going training they received in their roles. This training was predominately 'e-learning', which staff told us they often did not have time to complete. One member of staff told us, " There is absolutely no time for training or development." Another member of staff told us about the quality of training provided, " I find from the training here, you don't get anything back from it." We spoke with the provider about staff training and development. They told us there was a designated training officer, who oversaw staff inductions and training needs. However, when we spoke with this member of staff, they told us they were unaware they held such a role. This raised concerns with us about how staff training and inductions were being managed.

In addition to the lack of induction, staff told us they did not receive formal supervisions from management. Supervisions are one-to-one meetings between a member of staff and their line manager and are used to discuss work performance and training and development needs. One member of staff told us, "It would be really nice to have supervisions and appraisals." Another member of staff told us, "Because the communication is so poor here and there is no leadership, we need supervisions so that we can be told what we need to know; told whether we are doing our jobs properly; and for us to be given the opportunity to offload a bit." Following our inspection, the provider told us they would be responsible for providing supervisions for care workers, and the clinical lead would be responsible for clinical supervision for nursing staff.

We considered whether people had access to a range of healthcare professionals, as required. People's care plans contained up-to-date information about their medical appointments, as well as guidance from healthcare professionals. For example, guidance was in place from physiotherapists and the speech and language therapy team. Staff we spoke with were aware of this guidance and ensured it was adhered to. We saw input had been sought from a range of different healthcare professionals and services, including diabetic eye screening, audiology, chiropodists and pacemaker clinics. This was to support people to maintain their health, and respond to any changes in their healthcare needs.

We saw the design and adaptation of the building was accessible for people, with people able to navigate their surroundings with ease. One person used a patio area when they wanted to go outside to smoke. Another person enjoyed access to the garden and also enjoyed sitting in a communal area, mostly used by them, with the patio doors open. They told us, "I am a country girl and I hate feeling shut in." Staff recognised it was important for this person to have access to fresh air and the outdoors.

Requires Improvement

Is the service caring?

Our findings

We found that individual staff members displayed patience, warmth and respect in their approach towards people. There were instances throughout our inspection where staff were able to soothe people who were showing signs of anxiety, and people were comforted by this and relaxed in staff's presence. People we spoke with told us they had no concerns about the manner in which staff spoke with them. One person told us, " They staff are very good to me; I can't complain." Another person told us, " Satisfied is the word I would use (about the care). It is neither very good, nor very bad." However, due to a lack of staff, people were sometimes placed in undignified situations and did not always have their personal care needs attended to promptly. People had to wait up to an hour to be assisted with their continence needs, which caused them distress. A member of staff we spoke with told us, " Personal care does suffer. It is very challenging; people get neglected, particularly the quieter ones."

The staffing levels also limited people's choices in terms of how they wished to be cared for. One member of staff told us, "We know there are people here who would like to get up in the morning, have a bath or a shower, then have their breakfast. But this just isn't possible as a lot of people need two carers to help them to bathe and get them up. So they have to stay in bed until the afternoon when there is more time; it breaks my heart." One person we spoke with confirmed that staff time pressures meant that their preferences about their care was not always acted on. They told us, "I am asked where I would like to sit, but then there is no one to move me so I have to stay where I am." During day three of our inspection, one person was calling out for staff help as they wanted assistance with getting out of bed. A member of staff told us, " [Person] asked to go to bed this afternoon, which is where they are now. They must have changed their mind and now want to come out of their room again, but the trouble is all the staff are now busy helping people with their tea, so [person] will just have to stay where they are. It's not right."

People's care plans contained 'This is Me' documents', which is an Alzheimer's Society tool to help staff to understand people at the home living with dementia, and contains information about life histories and likes and dislikes. We found that staff knew people as individuals, including their likes and dislikes and personal preferences. One person supported a particular football team, and staff were aware of this and its importance to the person. Another person enjoyed speaking about their home town and their life history, However, staff told us they did not have time to spend with people to chat about their hobbies and interests. One member of staff told us, " The sad thing is, we (staff) would love to spend quality time with people; we want to care. But there just isn't the time, and they suffer as a result." Another member of staff told us, " I'm here to care, but I don't get the chance. It is quick washes for people, then they are left again for ages. " This was reflected in what people told us, with one person telling us, " I love to chat, me. But there is no one to talk to."

Links were in place with local advocacy services, and one person was visited by their advocate during the course of our inspection. Advocates represent people in decisions about their care and ensure their voices and opinions are heard. Staff we spoke with understood the role and importance of advocates for people who have communication difficulties and may need someone to uphold their rights.

Inadequate

Is the service responsive?

Our findings

At our previous inspection, we found the service was not always responsive in regard to people's needs. Examples included people not always getting their personal care needs attended to in a timely way, and delays in responding to people's requests for staff assistance. At this inspection, we found these concerns remained. One person had pressed their call bell for help, but there were no staff available to respond. This person started to attempt to climb over their bed rails, which had been put in place for their safety. We had to intervene to assure the person we would get someone to help them. We also found that not everyone's call bell was working, and that some of the call bells were out of people's reach. Had the call bells been within their reach, they would have been able to use them. This meant that people were not able to alert staff to their need for help when they needed to. This was raised with the provider during the inspection, who told us they would take immediate action to remedy the position and working order of the call bells.

At our previous inspection, people gave us mixed responses about whether they were able to enjoy their individual hobbies and interests. At this inspection, people and staff continued to express concern about this. One person we spoke with told us, "There are some things to do, fun things, but they don't come around that often. I tend to just sit here watching the world go by." Another person we spoke with told us, "They (activities) aren't that interesting to me." We spoke with the activities coordinator, who told us how difficult it was for them to make sure they met the needs of all the people living at Stretton Nursing Home. They told us, "I am meant to do two activities a day, plus all the 1:1s, and I have to plan it all as well. I don't feel (the provider) supports us with activities. We set up a lovely reminiscence room for people, and they used to really enjoy it; we put our heart and soul into it. But [the provider] told us it was too cluttered and had to go." At the time of our inspection, the reminiscence room was no longer in use. Reminiscence work is a way of stimulating the memories of people living with dementia and engaging them in conversation about their past.

Although there were individual care plans in place for people, these were not always reflective of their current needs. For example, staff had expressed concern over a change in one person's behaviour. Staff had recorded their concerns and had logged notable incidents, but there was no behavioural support plan in place for the person, nor was there any evidence of the incident forms being reviewed and acted on. One member of staff told us, "The carers are making a note of our concerns, but I am not sure what the point is as no one ever seems to read them. We haven't been advised on what we should do to help [person's name], or whether we should do anything differently." Staff expressed concerns over another person and behaviours which challenge, and how their needs were not being responded to. We observed throughout the course of our inspection that the person's behaviours caused distress to other people living in the home and that staff were unsure how to meet the person's needs.

Another person had a catheter care plan in place. However, the plan did not specify what type of catheter was in place. After staff told us what the type of catheter was, we found the care plan contained incorrect information about how often it should be changed. Staff confirmed they had been changing the catheter in accordance with the care plan. This placed the person at risk of not having their catheter changed at the required frequency, which may affect their health.

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

There was a system in place for capturing complaints and feedback. The provider was able to demonstrate to us how they had responded to a verbal concern raised by a family member, and what action they had taken. However, the provider was unaware of their requirement to adhere to the Accessible Information Standard ("AIS"). The AIS places a requirement on publically-funded bodies to ensure that key information is provided to people in accessible formats. One person living at the home was visually impaired, but documents such as the complaints procedure and the service users' guide were only in standard written format, rather than other formats such as audio or large print. We explained to the provider the requirements of the AIS and the importance of ensuring information about people's care was in accessible formats for them.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance systems and processes had not enabled them to identify and address significant shortfalls in the quality of the service. At this inspection, we found improvements had not been made and the provider remained in breach of this regulation. At the time of our inspection, the registered manager had been absent from work for a period of four months. There was no acting manager, deputy manager or clinical lead in place.

Quality assurance systems and processes remained ineffective. For example, we looked at the weight loss monitoring system. Whilst people were weighed regularly and their weights documented, no one had responsibility for monitoring this. One person's weight loss data showed a weight loss of over 36 KG in three weeks. This weight loss had been recorded in two separate places. Under the section of the weight loss record called , 'action taken', staff had simply written "weight loss." Because this information was not reviewed, this had not been identified as being of concern, nor had steps been taken to investigate whether the weight had been recorded accurately. We raised this with the provider, who ensured the person was weighed that day and their correct weight recorded. Whilst it transpired this had been a recording error, it illustrated the lack of clinical oversight in regard to monitoring people's weight.

As referred to previously in the report, we found significant concerns around pressure care, infection control and medicine management. There were no audits in place for these key areas, which meant the shortfalls had not been identified prior to our inspection. By failing to identify these shortfalls, it meant that remedial action had not been taken, which placed people at risk of on-going harm.

We spoke with the provider about the lack of effective quality assurance systems. They told us they recognised this was an issue, and that they had appointed a deputy manager and a clinical lead; the clinical lead's first day coincided with our inspection. We asked the clinical lead what their understanding of their role was, and we found this differed greatly from what the provider's vision was. The clinical lead told us, " As far as I am concerned, I am here for two weeks to review care plans. " However, the provider told us the person would undertake clinical supervisions with the nursing staff, implement a dependency tool and carry out a review of people's clinical needs. This disparity was a particular concern to us as we found, and staff told us, a lack of clinical leadership was affecting the care people received. One member of staff told us, " It is very unsafe at the moment. The communication is appalling. We raised concerns with the nurses about a person having suspected shingles. I think a GP came out, but we have no idea of the outcome and there is no one there making sure we all know the things we need to know."

Staff we spoke with expressed feelings of low morale and uncertainty in their roles. One member of staff we spoke with told us, "Everything needs to change, but nothing has." Another member of staff told us when asked what the main pressures of their roles were, "Everything. We're just trying to sort it out by ourselves. " A third member of staff told us about their high levels of stress at work and how they worried about making a mistake as a result. They described working at the home as, "Very, very unsafe. And very scary." We spoke with staff after the provider had increased the staffing levels. Whilst staff acknowledged this eased some of

the pressure they were under, they questioned why the levels had only been increased now. One member of staff told us, " [The provider] is approachable, yes, and they do listen to us. But listening is all very well and good, it is the action we need. We've been saying for months and months we need at least five carers on each side, but nothing was done about it." Another member of staff said, " I don't feel valued or supported. If we were valued, we would be fully staffed and we wouldn't feel stressed." We spoke with the provider about these concerns, who told us the difficulty was that some days were very 'calm' at the home and the previous staffing levels had been adequate, but other days had been more challenging. However, they recognised staff's frustration about the delay in taking action to increase the staffing levels.

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

Also at our previous inspection, we found the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had filed to notify the CQC of a safeguarding issue involving a person who used the service. The provider completed an action plan, which stated the CQC would be notified in a 'timely manner' in the future, and at the same time as the local authority. At this inspection, we found that whilst the provider was now submitting notifications as required, there was evidence of a further safeguarding concern from September of last year which we had not been informed of. The provider told us they had been unaware at that time of their requirement to submit statutory notifications.

This was a continued breach of Regulation 18 of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider told us they recognised significant improvements were needed to the quality of care people received, and that they were committed to working in partnership with other agencies to achieve this. During and immediately after our inspection, the provider sought advice from another local provider and asked them to support them in a mentoring capacity. The provider also implemented the urgent recommendations from the local authority and the Clinical Commissioning Group.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act were not adhered to in regard to least restrictive practice and best-interest decision-making. A number of people were cared for in bed in their 'best interests', without other, less restrictive options being explored. Decisions made about caring for people in bed had been made in isolation and without input from health professionals, family members or advocates.

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 RA Regulations 2014 Safeguarding service users from abuse and improper treatment Where members of staff had failed to report witnessed or suspected abuse or harm, the provider had not taken action to keep people safe. People continued to be cared for by staff who had failed in their duty to safeguard them from abuse or improper treatment.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not reflective of their current health and wellbeing needs, and contained inaccurate information. As staff relied on people's care plans to inform their daily practice, people were at risk of harm and neglect because their needs were not met appropriately.

The enforcement action we took:

A condition was placed on the provider's registration which meant they had to send us monthly reports to demonstrate how this Regulation was being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered in accordance with the prescriber's instructions, which placed people at risk of receiving sedative medicines they did not require. Where there were known skin infestations, bacterial infections and blood-borne viruses amongst people living at the home, infection control measures were not in place to contain this and prevent the risk of further infection. Risk assessments were not in place for conditions such as epilepsy, nor was there clear repositioning guidance in place for staff to follow to maintain people's skin health.

The enforcement action we took:

A condition was placed on the provider's registration which meant they had to send us monthly reports to demonstrate how this Regulation was being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 14 HSCA RA Regulations 2014 Meeting

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	nutritional and hydration needs People did not receive the assistance they needed to eat and drink. Where people expressed symptoms of dehydration, action was not taken to ensure they received fluids. Drinks were left out of reach for people, and meals were left to go cold as there were no available staff to encourage and support people to eat. This placed people at risk of malnutrition and dehydration.

The enforcement action we took:

A condition was placed on the provider's registration which meant they had to send us monthly reports to demonstrate how this Regulation was being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of managerial oversight and clinical leadership in the home, which affected the quality and safety of the care provided. There were no mechanisms in place to identify shortfalls in the service, nor risks to people's health and wellbeing. Systems used to monitor people's health were ineffective.

The enforcement action we took:

A condition was placed on the provider's registration which meant they had to send us monthly reports to demonstrate how this Regulation was being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were insufficient to meet people's personal care, continence, nutrition, hydration and emotional needs. There was no dependency tool in place to determine a safe level of staff. People were caused emotional distress by having to wait for staff assistance.

The enforcement action we took:

A condition was placed on the provider's registration which meant they had to send us monthly reports to demonstrate how this Regulation was being met.