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Stamford House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Stamford House Care Home is a residential care home providing personal and nursing care to 21 people aged 65 and over at the time of the inspection. The service is registered to support up to 23 people.

People's experience of using this service and what we found
Poor management of fire safety and legionella put people at risk. Staff were not all trained in health and safety. The home was clean, but some carpets needed replacing and some areas of the home required refurbishment.

Medicines were administered safely, staff ensured creams were stored safely following the inspection. The registered manager was improving how they managed incidents and accidents. Good practice was not consistently followed when recruiting staff. We have made a recommendation about staffing.

People did not always receive person-centred care and care plans needed further development. New staff had started to work at the home before completing an induction and training, but had now completed an induction course.

There were limited systems in place to monitor the quality and safety of the service provided. The registered manager and provider took steps to mitigate risk during and following the inspection. For example, carrying out fire safety checks and completing risk assessments.

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

Rating at last inspection
The last rating for this service was good. (published 17 September 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management of incidents. A decision was made for us to inspect and examine those risks. We have found evidence the provider needs to make improvements. Please see the safe and well-led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Stamford House Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to environmental safety, incident management, staff training, recruitment, person-centred care and leadership.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Stamford House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that when registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also gathered information that Healthwatch held about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and five relatives. We spoke with nine staff members including the registered manager, the deputy manager, the operations director, a housekeeper, the cook and care staff. We reviewed a range of records including care records for six people. We looked at medicines and records about medicines for four people. We spoke with a senior carer who had responsibility for administering medicines on the days of the inspection. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including health and safety records were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies and procedures. We spoke with two professionals who had visited the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were placed at risk because fire safety was not safely managed. The provider and registered manager had not actioned all the recommendations on their most recent fire risk assessment. For example, not all staff had completed fire safety training. Following the first day of the inspection we referred the home to the local fire prevention team. The provider took action during and following the inspection to improve fire safety at Stamford House Care Home.
- The provider and registered manager had not ensured risks were assessed in relation to Legionella. The registered manager took action during our inspection to arrange the necessary assessment and water checks and provided evidence this would take place following the inspection.
- People were at increased risk of harm because radiators were hot to the touch on the first day of the inspection. Not all radiators had appropriate coverings. Two radiators had loose coverings. The registered manager arranged for the loose coverings to be reattached during the inspection. The provider confirmed they would arrange for the uncovered radiators to be covered following the inspection. On our second day of inspection radiators were cooler.
- People were at increased risk of falls because furniture was in poor condition. For example, broken drawers were obstructing the floors in bedrooms. The provider assured us they were replacing broken and unstable furniture with fitted units during a programme of improvement due to start in December 2021.
- People were at risk of aggression from other residents, or self -neglect because risks were not effectively assessed or recorded and there was limited guidance or strategies for staff to follow.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were at risk of experiencing pain and neglect. Risks relating to pain were not always assessed or recorded and there was limited guidance for staff to follow. A potential safeguarding concern was identified whilst the inspection was taking place and an investigation was opened by the local authority.

The provider had failed to ensure systems and processes to prevent abuse of people operated effectively. This was a breach of Regulation 13 (safeguarding service users from improper care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and provider had a safeguarding policy in place. This inspection was triggered by concerns about the management of incidents and safeguarding alerts. The registered manager

demonstrated they were aware of local procedures for reporting safeguarding concerns and explained what they had learnt from an incident that had occurred at the home.

Staffing and recruitment
● The provider and registered manager had not always followed safe recruitment practices. For example; evidence had not always been checked that prospective staff had the right to work in the United Kingdom, a full working history of staff had not always been recorded, and risks were not assessed when staff had only provided one reference.

The provider had failed to operate an effective recruitment process. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us there were enough staff to support people and the registered manager told us staffing levels were appropriate. However, we observed during our inspection the main lounge area of the home was often left unsupervised as staff were working elsewhere in the building. We also noted some people had not had high quality support with their personal care needs.

We recommend that the provider review the deployment of staff to ensure people receive appropriate supervision and support with personal care.

● People told us staff were kind to them. One person said, "The staff are top notch, very helpful. I am content here."
● Two relatives we spoke with told us staff were excellent and they had no concerns about the care at Stamford House Care Home. One relative said, "Staff have worked at the home a long time and the [registered] manager seems great."
● However, three relatives shared concerns about their loved one's care and physical presentation. One told us, "The management team could be more responsive and proactive when dealing with family requests and make sure they follow things through."

Preventing and controlling infection
● The home was clean and domestic staff were working throughout the home during the inspection. However, we noted gaps on cleaning charts and staff rotas demonstrated there was a lack of domestic support on some days of the week. This meant that cleanliness may not be continuously maintained at the home. The registered manager assured us they were increasing the hours for domestic staff and had been recruiting for this role.
● People did not always have a clean and odour free in their bedroom. The provider assured us that flooring was being gradually replaced throughout the home and would be replaced in priority order. The registered manager had ensured one carpet was deep cleaned following the first day of the inspection.
● The registered manager had put PPE stations in place across the home, so staff had access to appropriate equipment to prevent the spread of infection. Staff wore appropriate PPE when delivering care at the home.
● The registered manager ensured that people using the service, staff and visitors were subject to appropriate testing to prevent all at the home and visitors from catching and spreading infections.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● People told us they received their medicines on time and were happy with the support from staff.

Controlled drugs (medicines that are subject to stricter control because of the risk of misuse) were stored and handled safely.

● People's medicated creams had been left in several bedrooms. The registered manager immediately removed these to store these safely.

● Staff had not always had their competency to administer medicines assessed. The registered manager assured us they would arrange this following the inspection. Staff administering medicines on the day of the inspection demonstrated a good level of understanding about medicines and knew people's needs well. We made a recommendation about the recording of thickeners which was actioned immediately.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were shortfalls in service leadership. Leaders and the culture they created did not always assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Audits to monitor health and safety had not identified risks relating to environmental safety. The registered manager told us they felt supported by the provider. However, there was limited evidence the provider effectively reviewed the performance of the management team.
- The registered manager had not always understood their regulatory obligations in relation to sharing information with CQC. Following the inspection, the registered manager was proactive in seeking further training to support their development.
- The registered manager and provider had not always updated people, relatives and professionals in a timely way following an incident. The registered manager told us they had reflected on this and had improved systems to ensure key individuals were informed about incidents at the earliest opportunity.
- The registered manager and provider had not ensured that people's confidential information was held securely. During the inspection information about people was found to be accessible on a computer in a corridor, and a cupboard shelf full of files that appeared to contain personal information was left accessible from the same corridor.

The provider had failed to assess and monitor the quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager ensured that medicines were audited regularly, and mattresses were clean and in good condition.
- The provider and registered manager were committed to the improving the delivery of safe and compassionate care at the Stamford House Care Home. They took steps during and following the inspection to make improvements. The registered manager had already made improvements to many communal areas of the home to make people more comfortable since taking up their role and was receptive to feedback given following the inspection.

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

- People did not always receive high-quality personal care. For example, people had overgrown toenails. The registered manager assured us the podiatrist was booked to visit the home and they would prioritise the people that most needed footcare.

● People were usually allocated one shower per week and records did not demonstrate that people were having regular showers. Bathing facilities were dated and the bath was not safe to use because it had no safety belt fitted to the bath hoist. This meant people could not choose to have a bath instead of a shower and did not have access to a pleasant bathing experience.
● People's basic needs were captured in care plans. However, care plans and risk assessments required further development to capture people's level of independence and provide detailed instructions for staff to follow. Staff had not always recorded care interventions consistently.
● People did not always have privacy when using their bedrooms because some bedroom doors had windows in them. The registered manager covered the windows in bedroom doors following the first day of the inspection.

The provider had failed to ensure staff provided people with individualised care which met their needs. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● Staff had started to work at the home during the pandemic without having access to mandatory training or completing an induction. The provider was aware of this before the inspection and had already purchased a training package which staff had started to complete.
● Staff had not received recent training in moving and handling or had their competency checked in this area. The provider assured us this training had been arranged during the inspection.

The provider had failed to ensure training, learning and development needs of individual staff members were carried out at the start of their employment. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had invested in a digital care planning system to capture people's care needs and reduce the burden of paperwork on staff. The operations director told us, "We are exploring how we can optimise the care planning system to improve care for people."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff told us they felt able to share concerns with the registered manager and they were supported in their role. Staff said the registered manager had supported them through the Covid-19 pandemic. Regular team meetings had taken place.
● Professionals who had visited people at the service told us the registered manager had been receptive to their feedback and was trying to get things right at the home.
● The registered manager had started to complete reviews over the telephone with relatives to ensure they could contribute to their family member's care plans. One relative told us, "Staff have communicated effectively with us over the phone during the pandemic and I think my [family member] is doing ok."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure staff provided people with individualised care which met their needs. Regulation 9 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes to prevent abuse of service users operated effectively. Regulation 13(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure information about candidates set out in Schedule 3 of the regulations was confirmed before employment. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure training,

learning and development needs of individual staff members were carried out at the start of their employment.

The provider failed to provide ongoing supervision in each staff member's role to make sure competence was maintained.

Regulation 18 (2) (a)