Angels (Stratton House) Ltd

Angels (Stratton House) Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Angels (Stratton House) Ltd is a nursing home and was providing personal and nursing care to 17 people aged 65 and over at the time of the inspection. The service can support up to 24 people. Accommodation is laid out over two floors that can be accessed by stairs and a lift. Each floor provides bedroom accommodation, most with en-suite facilities and people have shared access to one bathroom and one shower room. To the ground-floor there are two communal lounges, dining room, and level access to front and rear gardens. The registered manager's office can be found on the first floor.

People's experience of using this service and what we found
There was a lack of provider oversight of the service and the quality of care provision. Governance systems either did not exist or were not used effectively to identify the concerns, errors and omissions we identified during our inspection. The staffing structure did not always promote effective communication and staff did not always speak about people in a person-centred way. We found one statutory notification had not been submitted in line with requirements. There was no oversight of safeguarding in the service. The systems in place failed to support staff to recognise and identify that unexplained bruising may indicate potential abuse or neglect.

People were at risk from the spread of infection because staff had not received suitable training in relation to the application and management of personal protective equipment (PPE). When risks were identified, they were not always managed in line with assessments. Staff were not recruited safely, and we received mixed comments about staffing levels in the home. Staff were not always undertaking training relevant to the needs of people they were supporting, and some
training was overdue.
The manager was working with a recognised training provider to implement a new training programme.

People were supported to eat and drink enough, however alternative meal choices were not always available.

The recently appointed manager was in the process of implementing changes, including introducing new ways to engage with stakeholders. Staff said they felt part of a team, and relatives spoke positively about staff.

People were supported to access healthcare and external services.

The manager had identified that the premises were not always suited to people living with dementia and was working to improve this.

Routine health and safety checks were being completed. Improvements had been made in relation to the management of medicines.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 25 September 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to food provision and staffing levels in the home. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We 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.
We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Angels (Stratton House) Ltd 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 safeguarding people, infection prevention and control and risk assessment and management. Additional breaches relating to recruitment and staff training and the service's quality assurance systems were also identified.

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

sooner.

Special Measures
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

Angels (Stratton House) Limited

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of two inspectors.

Service and service type
Angels (Stratton House) Ltd 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 did not have a manager registered with the Care Quality Commission. The manager had submitted their application to register with us.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the provider, manager, care co-ordinator, senior care workers, and care workers. We observed lunch times during both days of the inspection.

We reviewed a range of records, including people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with relatives and requested feedback from professionals who had worked with the service. We issued an urgent action letter to the provider in relation to serious concerns about infection prevention and control practices in the home.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection we identified concerns in relation to infection prevention and control. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection;
- People were not always protected from the potential spread of infection.
- Staff had not received training about the correct application, management and removal of PPE. We observed staff throughout both days of the inspection removing their face masks to below their nose or chin. This meant face masks would not be effective at preventing the spread of infection.
- Photographs displayed in the dining room showed staff with their masks secured beneath their nose or chin and not observing social distancing guidelines. The failure to adhere to social distancing guidelines risked the spread of COVID-19.
- Staff COVID-19 testing was not being undertaken in the designated testing room. Instead, a table in a communal area was being used as a testing station. We observed recently completed COVID-19 tests, on the table, waiting for results to develop. This posed a risk of cross-contamination.
- Signs throughout the home and in people's bedrooms were not always laminated to reduce the risk of infections spreading.

Assessing risk, safety monitoring and management
Risks to people were not safely or effectively managed.
- People were sometimes placed at risk of choking or aspiration. Staff had mixed understanding around how to support people safely with eating and drinking. One person was assessed by speech and language therapists (SALT) as requiring thickened fluids. During the inspection, an inspector had to intervene when they observed the same person being supported to drink un-thickened fluids.
- People at high risk or very high risk of developing pressure ulcers were placed at risk of potential harm. Some people required specialist air mattresses to help prevent pressure ulcers developing. The manager had implemented a system aimed at supporting staff to correctly check air mattress settings. However, one person who was assessed as being at very high risk of developing pressure ulcers, had their air mattress incorrectly set. This increased the risk of the person developing a pressure ulcer. The management team was not aware of this when we raised it with them, they did act to correct the setting during our inspection.
- Two people at very high risk of pressure ulcers had developed red areas on their skin. One of these people was seen sitting in the same position for long periods of time in the lounge. Staff had mixed understanding of their repositioning needs to reduce risks of pressure ulcers developing. Care plans indicated frequency of repositioning however; the daily records did not demonstrate this was happening.

● Systems in place for sharing changes and updates with staff about pressure care were not effective. For example, the manager told us they had informed senior care staff about updates to systems in relation to repositioning. However, senior care staff were not aware of who they should tell about the changes.
● People were placed at potential risk of harm in the event of a fire. There was no fire risk assessment for the home, which is a legal requirement. Over ten occasions, fire safety checks had identified improvements were needed to improve fire safety. No action had been taken.

The failure to ensure people were adequately protected from the risk of harm and additional failures to implement effective infection prevention and control measures was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to our feedback, the manager reminded staff to wear their PPE correctly and also contacted the local authority to arrange a training session for all staff.
● Routine checks were being carried out in relation to health and safety systems. For example, moving and handling equipment had recently been checked for safety and an external company had checked some fire equipment.
● The provider had recently increased the number of cleaning staff rostered and employed by the service. This meant a cleaner was now on site seven days a week. Overall, the premises looked clean.
● People had Personal Emergency Evacuation Plans (PEEPS) that detailed support people needed in the event an emergency required people to evacuate the building.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse.
● There was no oversight of safeguarding in the service. The provider had failed to establish systems that ensured safeguarding concerns were dealt with correctly and given the right level of scrutiny.
●There was no collation and analysis of safeguarding information to ensure potential incidents, themes and trends were identified. This meant the provider could not identify potential safeguarding patterns and risks and act to prevent a recurrence.
● Unexplained bruising was not always identified as a potential safeguarding concern that may require further investigation and referral to the local safeguarding team. This meant people were at risk of experiencing physical abuse that may go undetected.
● Staff did not always have up-to-date safeguarding training. For example, records for eight staff showed their safeguarding training was overdue.

The provider failed to ensure there was sufficient oversight and scrutiny of safeguarding in the service. There was an additional failure to identify occasions of unexplained bruising as potential safeguarding concerns. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We made four safeguarding alerts to the local authority safeguarding team in relation to incidents of unexplained bruising.
● Staff we spoke with were confident about reporting suspected and witnessed abuse. For example, one staff member said they would report concerns to the manager and write a statement. They confirmed they would escalate concerns to the Care Quality Commission and local authority if the concerns weren't responded to appropriately. However, although unexplained bruising was recorded, staff had not always escalated unexplained bruising for investigation.

Staffing and recruitment

● Staff were not recruited safely.
● Staff files did not always include information required by the relevant legislation. For example, five recruitment files we reviewed did not include a full employment history. Ensuring applicants provide a full employment history is important because, for example, it helps prevent applicants from hiding previous poor conduct.
● Staff files did not always include a reference from the staff members' most recent employer in care. We reviewed one staff recruitment file that included a reference from their friend and a former colleague. This meant the provider could not be assured staff had acted with good character in their previous role.
Information needed to recruit staff safely was not always acquired and checks were not always completed in line with relevant legislation. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The manager was using a staffing dependency tool to allocate staff across the home and identified that the service had reduced the numbers of agency staff they used.
● We received mixed comments about staffing levels in the home. Comments from staff included, "Sometimes there are not enough staff" and, "Staffing could be improved [some days] there are too many and other days there are too little."
● The manager acknowledged the service had experienced staffing shortages caused by COVID-19, for example when staff had to shield or had tested positive for COVID-19. More recently, staffing levels had improved and, overall, the home was staffed in line with the requirements of the staffing dependency tool.
● At the time of our inspection, the provider had a vacancy in the clinical team, and was actively working with recruitment agencies to fill the post. The clinical lead was working additional hours to ensure people's clinical needs were met.

At our last inspection the provider failed to ensure protocols for 'as required' medicines were sufficiently detailed, and people had been placed at risk of harm from incorrectly stored thickeners. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to medicines management.

Using medicines safely
● Medicines were now being managed safely. People were receiving their medicines on time and in accordance with their preferences.
● Medicine was stored securely in line with legislation and when medicines required refrigeration, the temperature of the fridge was regularly checked. However, improvements were needed to ensure the maximum and minimum temperatures of the fridge were identified and recorded. The clinical lead assured us they would implement this.
● Staff told us they were applying topical creams. However, it was unclear how frequently and there was no guidance to ensure the applications were consistent. The management team were updating the daily paperwork to improve this.

Learning lessons when things go wrong
● The manager recognised that improvements needed to be made and lessons should be learned. The manager said they planned to, "Actively engage with [the staff] team on a regular basis and undertake group supervision sessions by way of regular team huddles."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not always received training relevant to their roles and peoples' individual needs. For example, the provider's website advertised the service as, "A specialist independent Nursing Home providing 24-hour care to residents with dementia or mental illnesses." However, staff had not received training in relation to mental health and not all staff had received specific dementia training.
- Some staff training was overdue. Records showed staff had overdue training in areas including first aid and person-centred care. This meant staff may not have the appropriate skills and knowledge to provide people with effective care.
- No staff had up-to-date fire safety training. Training records showed that fire safety training was either overdue or had not been completed.
- At the time of our inspection, staff were not supported to complete the Care Certificate. The Care Certificate helps those who have little or no experience of working in care, develop their basic skills and knowledge.

Staff were not always supported to access training relevant to their roles, some staff training had expired. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18

- The provider did not facilitate a formal induction programme; staff received an informal induction into the service. This included shadowing staff who were experienced in their roles.
- The manager was working with a recognised training provider to produce a training programme that aligned with peoples' individual needs. The manager said, "The right training is crucial, and it was important to find a training platform that was endorsed…to have the right training for all."

Adapting service, design, decoration to meet people's needs

- The manager recognised the environment was not always designed to meet the needs of people living with dementia.
- At the time of our inspection, the provider had purchased paint and planned to update areas in the home to make them more dementia friendly and help people find their way around independently. For example, painting door frames to make them more visible. Additional plans included working with relatives to personalise bedroom doors and introducing a sensory wall.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always offered menu options or a choice of what they would like to eat. For example, on one occasion the menu offered cream tea as the only option for an evening meal. During both days of the inspection, people were provided meals at lunchtime, without first being asked what they would prefer to eat.
● The menu in the dining room had not been updated to reflect the correct date and meal choices available. Instead, the board displayed the breakfast menu from three weeks prior to the date of our inspection.
● The manager had recently introduced initiatives to improve peoples' food intake and promote weight gain, including offering people smoothies and snacks in between meals. The manager had identified that most people had gained weight as a result. One relative said, "When [relative] went to [the service], they were really good at feeding him."
● At the time of our inspection the manager was in the process of reviewing the menu and had invited people and their relatives to contribute ideas for meals that could be offered in the future.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Peoples' needs were assessed, and care plans were produced to guide staff about how these needs should be met.
● Staff had assessed peoples' oral healthcare needs in line with published guidance and records showed people were being supported to maintain oral health.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The service was supporting people to access healthcare services and worked with professionals in the best interests of people. This included joining up with the local clinical commissioning group to review one person's care.
● The service made referrals to external professionals when the need arose. One relative said, "The nurses usually let me know they've contacted the GP and whether antibiotics have been prescribed" and another relative confirmed a person had been supported to access the optician and GP.

Ensuring consent to care and treatment in line with law and guidance
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.

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
● At the time of our inspection, seven people were subject to DoLS authorisations and the conditions of peoples' DoLS were being met. The manager was in contact with the local authority about applications that had been made where no outcome had been reached.
● People who lacked capacity or had fluctuating capacity had decisions made considering their best interest. For example, when people had bed rails in place to keep them safe this was assessed and decided in their best interest by the registered nurses.

● The manager had recently facilitated a COVID-19 safe, multi-disciplinary best interest meeting in relation to one person. Attendees included the person's relative and an independent mental capacity advocate.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no provider oversight in relation to the quality and safety of care provision in the service. Repeated breaches of regulations were found at this inspection. The provider told us COVID-19 had prevented them from visiting the home in person during the previous year. However, there had been no provider oversight previous to the COVID-19 pandemic and no initiatives, such as remote meetings and provider checks, had been introduced to ensure that some level of oversight was in place and maintained.
- Governance systems were not established and operated effectively, and this meant the concerns, errors and omissions we found during our inspection had not always been identified. This included shortfalls in relation to the protection of people, training and recruitment of staff and management of care and environmental risks.
- The provider had failed to act when fire safety checks raised the same fire safety concern on ten different occasions or ensure a fire risk assessment was in place.
- There was no recording or analysis of accidents and incidents to identify potential themes and trends to prevent a recurrence.
- The staffing structure did not always promote effective communication. For example, senior care staff were responsible for cascading certain information to care staff. However, there was no formal staffing structure to ensure senior staff were aware of who they should share information with and how this should be done. This meant there was a risk that care staff may not receive information relevant to safe and effective care provision.
- The provider failed to identify they had not submitted one statutory notification in relation to alleged abuse that was referred to and investigated by the local authority. Statutory notifications are important because they help us to monitor services we regulate.

The provider failed to establish and operate robust systems and checks to ensure good quality care provision. This was a breach of Regulation 17 (Good Governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The manager told us that quality checks and audits undertaken prior to their recent appointment may have been lost and were not always accessible electronically.
- The manager acknowledged that oversight and governance was lacking and told us they were implementing changes to improve this, including introducing a new programme of quality checks and audits.

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

● Staff did not always speak about people in a person-centred way. For example, we observed staff calling people who required support with eating their meals, "Feeds." We spoke with the manager who told us they had identified the term was inappropriate and had requested staff stop referring to people in this way.

● One relative wrote to the service, "The staff at Stratton House have kept us informed throughout this early settling in period and every member of staff we have met or spoken to has been professional, kind and caring and we just wanted to say, thank-you to everyone."

● Staff told us they felt part of a team. One staff member said there was, "A sense of a community and people helping each other." In one update to stakeholders the manager wrote, "We have had some amazing staff join the team…all very experienced staff and we are building a really great team."

● The manager operated an open-door policy so people, staff and relatives could speak with them when they needed to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The manager was implementing new ways of engaging with people, staff and relatives at the time of our inspection.

● Surveys were in the process of being sent to relatives and friends of people, those who couldn't participate or visit the home were encouraged to telephone and speak with the manager to share their views.

● The manager had recently started to facilitate staff meetings and topics for discussion included, staffing levels, COVID-19 and ensuring peoples' dignity.

Continuous learning and improving care

● The manager and care co-ordinator were looking at ways to improve care provision in the home. This included, updating and improving the garden and looking for ways to introduce experiences for people, such as inviting an ice-cream van to the home.

● The provider had recently employed a dedicated activities co-ordinator who would be responsible for supporting people to access person-centred activities.

Working in partnership with others

● The service worked with professionals and external organisations when the need arose. For example, staff had recently worked with a physiotherapist and referred one person to the GP. One professional said, "I have completed a couple of reviews over the phone or [via an online meeting] and these have been completed in a timely manner, the staff appear to be very knowledgeable of the residents and information about them has been made readily available."

● The manager had plans to build links with the local community, including a local school, and was researching the area for additional organisations they could work with to, "Make a difference" to people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibility to act in an open and transparent way when things went wrong.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Information needed to recruit staff safely was not always acquired and checks were not always completed in line with relevant legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always supported to access training relevant to their roles, some staff training had expired.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure people were adequately protected from the risk of harm and additional failures to implement effective infection prevention and control measures.

The enforcement action we took:

Warning Notice

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 failed to ensure there was sufficient oversight and scrutiny of safeguarding in the service. There was an additional failure to identify occasions of unexplained bruising as potential safeguarding concerns.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate robust systems and checks to ensure good quality care provision.

The enforcement action we took:

Warning Notice