Rotherham Healthcare Limited

The S.T.A.R. Foundation

Inspection report

Astrum House
Nightingale Close
Rotherham
South Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The S.T.A.R. Foundation, known locally at Astrum House is a specialist residential and nursing home providing support for up to 60 people. At the time of our inspection there were 53 people using the service. The service provides support for people with a learning disability, people with autistic spectrum disorder, mental health and people with a physical disability. Some people using the service were living with dementia. The home is separated into three units known as block A, B and C. Each block is then further separated in to five units of four people, these areas are known as pods.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. A small number of people living at the service had a learning disability and/or autism and did not always receive planned and co-ordinated person-centred support that was appropriate and inclusive for them. The outcomes for people using the service did not always reflect the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support did not always focus on them having as many opportunities as possible for them to gain new skills and become more independent.

People's experience of using this service and what we found

We identified a closed culture, people did not have their human rights upheld, protected characteristics were not recognised or respected and equality was not promoted.

The provide had systems in place to monitor the quality of service. However, these were not effective or robust and did not always identify areas of improvement. Some relatives we spoke with felt communication was poor. There was no evidence that feedback from people who used the service and their relatives had been gathered or acted on.

Risks associated with people's care were identified but were not managed in a way that kept people safe.

Staff were not always deployed effectively to ensure people's needs were met. Staff had not consistently received specific specialist training to meet people's needs. One to one support was not always provided in line with people's identified needs. Staff did not receive competency checks on their performance and abilities to ensure they carried out their roles and responsibilities safely.

The provider had a recruitment process in place which showed staff were recruited safely. However, monitoring of poor performance needed improving.

The provider had systems in place to safeguard people from the risks associated with abuse. Staff had received training in this area and were knowledgeable about how to safeguard people. However, following our inspection, we referred five safeguarding concerns to the Local Authority.

We identified shortfalls in the way people's medicines were managed.

People were not always protected by the risk and spread of infection.

Staff were kind in their response to people, however their approach was not always person-centred and at times was task orientated. Staff did not always respect people's privacy and dignity.

There was a lack of working together with external agencies to deliver effective care and treatment and support people's access to healthcare services. This meant their needs were not being met and had a negative impact on people's well-being and mental health.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

There was lack of evidence to show that people were involved in decisions about their care, support and treatment.

Most people we spoke with told us the food was nice. However, from observations it was not clear that people had choices, as meals came to the units pre plated. We identified weight loss, therefore it was not always clear that people's nutritional needs were met.

The environment was not appropriate and did not meet best practice in supporting people living with dementia.

Through our observations and from talking with people we found there was a lack of social stimulation and access to activities. People had limited access to the community and outside space.

During observations we found that specialist units did not use accessible information to enable people to communicate effectively.

Complaints were recorded in line with the provider's policy, however, there was no evidence to show what actions had been taken to minimise issues reoccurring.

End of life care plans were in place, but they did not always identify people's preferences and choices.

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 14 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, lack of social stimulation, not meeting the requirements of the Mental Capacity Act (MCA) and governance. Initially, we completed a site visit to look at the Safe, Effective and Well led key questions. Following the concerns, we identified, we completed a second site visit to include the key questions of Caring and Responsive.

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 coronavirus and other infection outbreaks effectively.

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

We have found evidence that the provider needs to make improvement. Please see all sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We wrote to the provider and asked them to take action to mitigate immediate risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The S.T.A.R. Foundation 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 safe care and treatment, privacy and dignity, consent to care and treatment, person centred care, staffing, safeguarding and leadership and oversight at this inspection.

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 continue to monitor information we receive about the service until we 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The S.T.A.R. Foundation

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 was carried out by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The S.T.A.R. Foundation 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 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
We gave a short period notice of the inspection. This was due to the COVID-19 pandemic to ensure we had prior information to promote safety.

What we did before the 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. 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 seven people who used the service and 12 relatives about their experience of the care provided. We spoke with 16 members of staff including the owner, registered manager, deputy manager, nurses, care workers and the cook. We observed staff interacting with people on each block. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three 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 five professionals who visit 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; Learning lessons when things go wrong
- Risks associated with people's care and treatment had been identified but not always managed, to keep people safe. For example, people had lost weight, and this was not monitored or reviewed to ensure staff were following advice from health care professionals. This put people at risk of harm.
- Accidents and incidents were recorded but not analysed; therefore, any themes or trends were not identified to mitigate risk and ensure lessons were learned.
- Environmental risks had been assessed and monitored and environmental safety checks were being carried out. However, we found areas of the environment that were not well maintained, therefore it was not clear if the checks were effective.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to robustly assess risks relating to health, safety and welfare of people.

Systems and processes to safeguard people from the risk of abuse
- The provider's system for safeguarding people was not always effective. Following our inspection, we raised five safeguarding concerns with the safeguarding authority. The provider had failed to recognise these safeguarding concerns.
- We received mixed views from relatives we spoke with. For example, one relative said, "I would probably say (relative) is safe, but not cared for properly." Another relative said, "Yes, (relative) is definitely safe."
- Staff told us they completed training in this subject and knew what actions to take if they needed to. However, we identified staff had not always taken action to safeguard people.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's system for safeguarding people was not always effective.

Using medicines safely
- People did not always receive their medicines as prescribed. For example, one person was prescribed medicines to take on a regular basis which provided relief from heartburn and acid indigestion and acute pain. The medication administration record) was blank indicating these had not been offered for a period of three weeks, with no explanation why and the person lacked capacity to tell staff when they required the medication.
- Protocols to guide staff were not in place where people were prescribed medicines to be given as and

when required. For example, some people were living with dementia and were not able to vocalise when they required medicines such as pain relief.
● Staff who administered medicines did not receive competency checks. Therefore, there was no evidence to support training was effective and medicines were administered following policies and procedures.
● Temperature of rooms used to store medicines were not monitored. Therefore, there was no evidence to support medicines were stored at the recommended temperatures.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe systems were not in place to manage medicines.

Staffing and recruitment
● The provider did not have a system in place to identify how staffing numbers were calculated based on people's dependency and the layout of the building. The registered manager confirmed this when asked.
● Some people we spoke with told us there were not enough staff around. One person told us they had to wait to have a shower or receive support.
● Commissioned staffing hours were not always provided to meet people's needs. For example, one person had been assessed as requiring one to one support. On the first day of our inspection we saw this person was very agitated and anxious; they did not eat their lunch and were left in their bedroom with no support. Staff told us that there was no one to one provided that day.
● Relatives we spoke with told us staffing levels were not adequate. One relative said, "(Relative) is massively depressed and lying in bed all day isn't helping, maybe they are short staffed."
● The provider had a safe recruitment system in place. However, systems in place to monitor poor performance required improvement.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider could not evidence that sufficient numbers of staff were deployed appropriately to meet people's needs.

Preventing and controlling infection
● People were not always protected by the risk and spread of infection. We found some areas of the home were not kept clean, this was due in part to poor maintenance. For example, we saw kitchen units were in poor state of repair and were gathering dirt and food debris which was difficult to keep clean. One person's bedding was stained, and fridge seals had gathered food debris.
● Linen store rooms had items stored on the floor making it difficult to clean. Flooring in two linen rooms was ripped and in need of attention.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Staff did not always wash their hands and sanitise them in-between tasks. For example, we saw some staff administering medicines and assisting with the food service without washing their hands first.
● We were assured that the provider's infection prevention and control policy was up to date. However, this was not always followed.
This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always protected from the risk and spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's physical, mental and social needs were assessed, however, their care, treatment and support was not delivered in line with legislation, standards and evidence-based guidance, to achieve effective outcomes.
- People's care plans we looked at did not include people's preferences and choices.

Staff support: induction, training, skills and experience
- Staff did not receive specific training to meet people's needs and to carry out their role effectively. For example, the providers statement of purpose stated they were a specialist service who could provide support for people living with a learning disability and/or autism. However, the provider did not provide staff training in this area.
- Staff did not receive competency checks on their abilities and performance to meet their roles and responsibilities.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive care and support from suitably trained and skilled staff.

Supporting people to eat and drink enough to maintain a balanced diet
- People were not always supported to maintain a healthy balanced diet which met their needs. For example, we identified people had lost weight, therefore it was not always clear that nutritional needs were met.
- Most people we spoke with told us the food was nice. However, from our observations it was not clear that people had choice, as meals came to the units pre-plated.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- Staff did not always work together to ensure that people received consistent, timely, coordinated, person-centred care and support when they were referred to different services. For example, people who required access to physiotherapy had not been offered this support during the current pandemic as the provider had denied physiotherapists access to the home. No alternatives had been sought and this had impacted on people's mobility.

● Healthcare professionals had been denied access to the home. We spoke with healthcare professionals and one said, "We were not allowed into the home by provider from start of lock down, I was going into other homes, I did raise this as a concern," and, "This meant people did not always receive the support from professionals that they required."

Adapting service, design, decoration to meet people's needs
● The service had a hydrotherapy pool and gym which were not in use at the time of our inspection. The registered manager told us this was due to the current pandemic. The service also had a sensory room. Staff told us this could be used; however, we did not see anyone using this facility during our inspection.
● The environment was not appropriate and did not meet the best practice guidance in supporting people living with dementia. The décor was bland and there was a lack of pictures, signage and tactile objects.

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.

● The provider was not always working within the principles of the MCA. For example, where decisions had been made on behalf of people, they had not always been completed in the person's best interests.
● People's DoLS conditions were not always adhered to. For example, one person's DoLS condition was for the provider to look at how physical activities could be optimised in the absence of physiotherapy during the current pandemic, however, this had not been addressed.
● People had limited access to the community and outside space. Professionals raised concerns that DoLS conditions to facilitate access to outside space, were not being met.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not always working within the principles of the MCA.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were kind in their response to people. However, we spent time observing staff interacting with people and found care and support provided was not always person-centred and at times task focused.
- People living with dementia were not supported in a meaningful way. We saw staff stood on the corridor observing people in the dining room and not interacting or providing encouragement to eat.

Supporting people to express their views and be involved in making decisions about their care

- People were not supported to express their views and were not involved in decisions about their care. For example, one person's care records had a do not attempt cardiopulmonary resuscitation (DNACPR) in place. We spoke with this person who indicated they did not want this in place and was unaware of it. We informed the provider who addressed this following our inspection.

Respecting and promoting people's privacy, dignity and independence

- There was a lack of regard for people's privacy. For example, one person was having a private conversation with a member of the inspection team, using assisted technology. A staff member entered the room without knocking and started reading what the person was writing. This did not show any respect for the person's privacy.
- People's dignity was not respected. For example, a person had a monitoring system in their bedroom with staff and visitors able to listen in from communal areas. This did not maintain their dignity.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people's privacy and dignity were respected.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive person-centred care which met their needs and preferences.
- Care records we saw did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences. For example, one person wished to attend a clinic and was not supported to do this.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. For example, one person had expressed a wish to attend church. This was not facilitated once places of worship re-opened following lockdown. This person would have liked to have gone, taking precautions but was not allowed to go.
- People who wanted to access outside space were not always supported to do this.
- People did not have access to social stimulation and activities. For example, one person was left in their room without stimulation. This person had been assessed by staff as requiring one to one support to reduce their anxiety, but this was not being provided.
- People were socially isolated. For example, a person accessed the community for educational reasons, but following their return to the service, had to isolate on a pod alone. We spoke with staff about this and were told the reason was due to the current pandemic.
- People and their relatives we spoke with were also concerned about the lack of social stimulation, activities and access to the community.

All the above evidence was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always provide person-centred care which met people's needs and preference.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● During our observations we found specialist units did not use accessible information to enable people to communicate effectively. For example, picture cards were available for meal choices, but these were not used.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure.

● We saw the registered manager kept a record of concerns and what action had been taken. However, some people and their relatives we spoke with told us they didn't feel listened to. Therefore, it was not evident the complaints procedure was effective.

End of life care and support

● Staff received training in end of life care. The training manager confirmed staff received training in end of life care supported by the local hospice.

● People had end of life care plans, but they did not always identify people's preferences, wishes and choices.

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 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

- The governance framework did not ensure that responsibilities were clear, and that performance, risk and regulatory requirements were managed. There was a lack of governance and oversight.
- The service had a registered manager who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. This person was unsure about their responsibilities as a nominated individual.
- The registered manager was supported by a deputy manager, who took over responsibility for the service in the absence of the registered manager.
- We spoke with staff and received a mixed view about the managers. One staff member said, "The nurses are the ones that lead, management stay in the office," and "Management are based in reception and they don't come onto the unit." Another staff member said, "There is no support from the nurses. They want to do as little as possible." Whilst other staff members said, "We have the best management I have ever worked under," and, "Management and staff are sticking together and trying to help us as much as they can. I find them very supportive."

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

- The provider did not promote a person-centred culture that ensured people achieved good outcomes.
- People were at risk of receiving poor care because risks to their safety and well-being were not mitigated or managed appropriately to protect them from harm.
- The service was supporting some people living with a learning disability but was not working in line with the principles of Registering the Right Support.
- The provider's statement of purpose did not reflect our findings.
- Through our observations and from speaking with staff, people and their relatives, we could evidence that a closed culture had developed within the service. This meant people were not always able to speak up for themselves, restrictive practices were being used, and management and staff make choices for people which are not always in their best interest.

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 nominated individual was not clear about their legal responsibilities as a nominated individual.
● We identified five safeguarding concerns during our inspection. These had not been previously identified by the nominated individual or referred to the safeguarding authority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Feedback from people, their relatives, professionals and staff were not documented and there was no evidence to show what actions had been taken to improve the service based on people's feedback. Therefore, it was not clear if lessons were learned to drive improvements.
● The registered manager had not instigated any service user or relatives' meetings during the current pandemic. Therefore, people had not been given opportunity to feedback about the service or to be kept informed about the pandemic. One relative said, "I have had no communication from the service since lockdown."

Continuous learning and improving care
● Systems in place to monitor the service were not effective. Some quality monitoring had taken place but had not identified the issues we found.
● Audits did not always identify areas for improvement and development. For example, we looked at the audit in relation to weight loss. We saw people's weight was recorded and the amount lost or gained, but no other review was carried out. Therefore, the audit was not effective in driving improvements and ensuring corrective action was taken. We looked at the infection control audit and found no areas of concern had been highlighted. This did not reflect the concerns we identified during our inspection.

Working in partnership with others
● The provider was not always working effectively with other agencies to support care provision.

All of the above evidence demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems in place to monitor the service were not effective.