Mr & Mrs S Blundell

Stanford House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Stanford House is a residential care home providing personal care and accommodation to up to 10 older people. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
People were not always protected from risks in the environment, such as secured windows or the storage of chemicals. Medicines were not always stored safely, but people received their medicines as prescribed. People's individual risks were not always regularly reviewed and documented. However, people felt safe at Stanford House and were satisfied with the support they received.

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.

Quality assurance systems were not always effective. Audits monitoring the quality of the service did not highlight the issues identified by our inspection. However, people and relatives felt the service provided a homely, family atmosphere which achieved good outcomes for people.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 December 2021) and there was a breach of regulation. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We carried out an unannounced focused inspection of this service on 21 October 2021. A breach of legal requirements was found. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve the governance systems at the service.

We undertook this focused inspection to check what actions had been taken and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stanford House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to how people's safety was managed and how the service was run 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 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

Stanford House

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 Health and Social Care Act 2008.

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
This inspector was carried out by 1 inspector.

Service and service type
Stanford House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Stanford House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the Well-led section of the full inspection report for further details. We used all this information to plan our inspection.

During the inspection
We spoke to 4 people and 3 relatives about their experience of the care provided. We spoke with 2 professionals who have contact with the service. We spoke with 4 members of staff including the registered manager and care staff members. We reviewed a range of records. This included 2 people's care plans, a range of medicine administration records (MAR) and 2 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems. We spent time observing the care that people received within the home.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- People were not always protected from environmental risks at Stanford House. Windows on the first floor were not restricted to prevent falls from height. An unsecured private area in the building contained several hazards. We observed hazardous chemicals such as cleaning solutions were stored in communal bathrooms. This put people at risk of harm through potential ingestion or spillage upon the skin by corrosive substances. The provider was responsive to our concerns and took swift action to mitigate these risks.
- People's medicines were not always stored securely. On both inspection visits to Stanford House, we observed eye drops and an inhaler left unattended in the kitchen of the service. In addition, some people's laxative medicines were stored on the medicines trolley, rather than locked inside it. We found some prescribed medicines had not been suitably disposed of. This meant there was a risk that people may take medicines that were not prescribed for them. The provider took action to ensure medicines were correctly stored.
- Documentation was not always in place to record people's medicines needs or risks. For example, risk assessments had not been formulated to consider the risk of flammable creams. Written protocols were not available for 'as and when' (PRN) medicines, to guide staff about their use.
- People's individual needs when evacuating the building had not been assessed and documented. This meant consideration had not been given to the support each person may need in the event of a fire, which could potentially place them at risk of harm. The registered manager took immediate action to address this shortfall.
- Infection control practices were not always robust. For example, we observed shortfalls in the standard of cleanliness in 1 bathroom where there was a soiled toilet brush and a stained toilet. There were areas of wear and tear in the home, such as worn carpets and furniture, that could impact the effectiveness of cleaning. The provider was aware of these issues and was working towards making improvements.
- Systems for monitoring risks to people's health were not always effective. Changes in people's weight were not reviewed to determine whether it was a cause for concern. People at a high risk of having a fall were not regularly reviewed to identify any changes to their needs. This meant there was a lack of oversight over whether additional actions were required to support people's health and wellbeing.

We found no indication that people had been harmed. However, effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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) Regulation 2014. After our inspection, the provider told us they

had taken action to mitigate some of the risks described above. We were provided with evidence that windows had been restricted to prevent falls from height. However, we are not assured at this time that risks to people will be consistently and effectively assessed and mitigated as the provider had not identified these concerns themselves.

● People received their medicines safely. Staff members had a good understanding of people's individual medicines and records showed these were administered correctly and audited by the registered manager.
● Care plans contained detailed information about how to support people's emotional wellbeing and how specific mental health conditions may present for people. Staff were knowledgeable about people's person-centred psychological needs.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● People were supported to make their own decisions about their support and treatment. For example, people were consulted and consented if they wished to have a COVID-19 vaccine.

Visiting in care homes
● Relatives told us they were supported to visit their loved ones as they wished. Visitors did not need to make an appointment and we saw loved ones freely attending the home throughout our inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People, staff and relatives told us people were safe at Stanford House. One person said, "I feel safe here, I don't feel like going out into the world." Another person told us, "It's a nice place, it's like a home from home."
● Staff had received safeguarding training and understood the signs of abuse and how to report any concerns they may have.
● The registered manager explained what steps they would take to learn lessons, should an incident occur. There wasn't a formal system in place, as incidents at the home were rare. However, staff knew people well and were able to describe how they might mitigate risks following an incident.

Staffing and recruitment
● Stanford House had an established staff team who had all worked at the service for many years. This meant staff understood their roles and knew people well.
● Staffing levels were maintained at the assessed level to support people safely. We observed staff being available to support people as required. People were relaxed and happy when engaging with staff members.
● Staff were recruited safely. We found pre-employment checks had been carried out including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment

decisions.

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 our last inspection we rated this key question requires improvement. The rating for this key question has changed 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; Continuous learning and improving care; 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

At our last inspection we found the provider had failed to ensure effective systems were in place.
This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Audit systems were not effective in identifying the environmental issues highlighted by our inspection. This included hazards in the environment, storage of medicines and shortfalls in infection control practices. This put people at an increased risk of harm.
- Processes for assessing and reviewing risks to people were not effective. People's risk assessments had not been reviewed since July 2021. This meant we could not be assured that any changes to people's risks had been identified and appropriate actions taken to keep them safe. The provider took immediate action to remedy this.
- Governance systems had not identified where the service had not fulfilled a statutory duty. It is a requirement for registered providers to notify CQC of certain events at the service and changes to the provider. Furthermore, it is a requirement for the service to provide information to CQC in the form is a Provider Information Return (PIR) when requested. The provider had failed to meet these requirements and lacked knowledge about how to do so.
- Processes to review fire safety were not effective. The provider's fire risk assessment was not dated and therefore it was unclear when this was last updated. Systems had not identified the need to assess people's individual evacuation needs in the event of a fire.
- Systems and processes for recording compliance at the service were not effective. For example, the cleaning schedule contained a list of tasks, but there was no formal system for recording when a task had been completed and who was responsible. In addition, whilst staff competency was reviewed by the registered manager, this was not recorded. This meant the registered manager had not documented which staff had competencies assessed and whether any staff needed additional support or training.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection, the provider told us they had taken action to mitigate some of the risks described above. However, we are not assured at this time that risks to people will be consistently and effectively assessed and mitigated as the provider had not identified these concerns themselves.

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

● Systems were in place to support people to work towards their goals. One person told us how they did not feel confident to go out into the community, but staff were going to help them build up their confidence once they felt ready.

● People's outcomes improved at Stanford House. Relatives told us they had seen improvements in their loved one's health and wellbeing since moving to the home. One family member said, "I looked at so many different homes and the care just wasn't there. This was by far the best place I saw. The staff have been here for over 25 years and it's their home as well."

● Staff spoke positively about their roles, the people they worked with and the support they received from the registered manager. One staff member said, "We are one big happy family." Another told us, "It's a good place to work. There's been no incidents in all these years."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Relatives told us communication with the provider was good and they would feel confident to raise any issues with management. One relative said, "I'd be the first to raise any issues. If [my relative] isn't well, they bring a doctor or nurse in straight away. For me, it's peace of mind."

● Systems were established to seek feedback from people, family and visitors to the service. We saw previous feedback had been analysed and was positive about the service people received.

● The service worked in partnership with other healthcare professionals in order to meet people's needs.

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 People were placed at risk of harm as windows above ground level were not sufficiently secured to prevent falls from height.

The enforcement action we took:

Notice of decision to impose urgent condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems and processes to drive the quality and safety of the service.

The enforcement action we took:

Notice of proposal to impose conditions.