Bupa Care Homes (CFHCare) Limited

Stadium Court Care Home

Inspection report

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Date of inspection visit:
15 December 2016

Date of publication:
05 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in November 2015. At that time we found the provider was meeting the required Regulatory requirements. After that inspection we received concerns in relation to the safety and management of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stadium Court Care Home on our website at www.cqc.org.uk".

The service is registered to provide accommodation and personal care for up to 168 people. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection 140 people were using the service. Five of these people were receiving in patient care at a local hospital. This report refers to our findings from inspecting three of the five units at Stadium Court. The three units we inspected were; Stafford, Spode and Aynsley. We were unable to inspect Wade unit due to an infection outbreak. Wedgwood unit was not included in this focused inspection because the inspection was completed in response to safety concerns that only related to the other four units.

We inspected three of the five units at Stadium Court. These Stafford, Spode, Aynsley and Wade. We spent time on Stafford, Spode and Aynsley unit, but were unable to inspect Wade unit due to an infection outbreak.

The service had a registered manager. However, they were no longer working at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had been appointed and they had been working at the home for approximately two weeks. The new manager told us they planned to register with us.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care.

Medicines were not always managed safely and people could not be assured that they received their medicines as prescribed.

People were not protected from the risk of infection as the environment, furniture and equipment was not consistently clean and hygienic. Some staff did not understand how to protect people from infections.

People were not always protected from the risk of abuse because suspected abuse was not always reported as required. Safe recruitment systems were not in place to ensure staff were of suitable character to work with the people who used the service.

Safety incidents were not always responded to effectively, which meant the risk of further incidents was not always reduced. There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

The registered manager and provider did not always notify us of reportable incidents and events as required.

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. Risks to people's health, safety and wellbeing were not always assessed, planned for, managed and reviewed to promote their safety.

Medicines were not always managed safely and a clean environment was not maintained which placed people at risk of infection.

People were not protected from the risk of abuse and avoidable harm. Incidents of potential or alleged abuse were not always reported to the local authorities safeguarding team as required.

Staff were not always available to keep people safe and meet people's care needs. Effective systems were not in place to ensure staff were suitable to work with the people who used the service.

Is the service well-led?

Inadequate

The service was not well led. Effective systems were not in place to assess and manage risks to people's health, safety and wellbeing.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Staff told us their concerns about the quality of care were not always listened to or acted upon to make improvements to care delivery.

The provider did not always notify us of reportable incidents.

Stadium Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Stadium Court on 15 December 2016. This inspection was completed in response to a number of safety concerns that had been shared with us by the local authority and visiting health and social care professionals.

We inspected the service against two of the five questions we ask about services: is the service safe? and is the service well-led? This was because the concerns we had received related to the safety and management of the service. These concerns related to four of the five units at Stadium Court; Stafford, Spode, Aynsley and Wade. We spent time on Stafford, Spode and Aynsley unit, but were unable to inspect Wade unit due to an infection outbreak.

Our inspection team consisted of four inspectors 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 service.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

We spoke with12 people who used the service and seven people who visited the service. We also spoke with nine members of care staff, four nurses and the home manager. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of 10 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

After our inspection, we shared our concerns and findings with the local authority. We did this because we believed people were at risk of significant harm to their health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

Risks to people's health, safety and wellbeing were not effectively assessed, planned for and managed to promote people' safety. We found that some people were at high risk of injury and harm as a result of frequent falls. A relative shared concerns with us about the number of falls their relation had suffered at Stadium Court. They said, "They have a lot of falls. I suppose it's to be expected though". We found that when people fell, they did not receive specialist assessment to identify what changes were needed to reduce their risk of falling again. One person's care records showed they had fallen on at least 16 occasions since September 2016. Their records showed a visiting nurse had seen them following a previous fall in August 2016 and had advised staff that a referral to physiotherapy or occupational therapy was not needed (physiotherapists and occupational therapists are specialists in mobility assessment and intervention). Despite the person's further 16 recent falls staff had still not considered seeking advice from a mobility specialist. The nurse we spoke with about this told us they relied on the advice of the visiting nurse (who was not a mobility specialist). As a result of this, no changes had been made to the person's care that reduced their risk of falling again.

Another person's care records showed they had fallen 12 times since October 2016. We saw the staff refer this person to the local falls team on the day of our inspection. This meant the staff did not complete this referral in a timely manner. The home manager told us action should be taken; such as referrals to specialists after just two falls. No explanation was given by staff to explain this delay.

Another person had recently fallen from their chair and injured their face. No assessment or action had been taken to prevent further falls from the chair from occurring and we saw this person seated in a chair unsupervised in an unsafe position. This meant this person was at risk of serious injury and harm due to ineffective assessment of risk and ineffective responses to safety incidents.

Some people were at high risk of skin damage and their care plans stated they needed assistance to change their position every four hours to prevent their skin from deteriorating. Care records showed people did not always get the support they needed every four hours as planned. For example, one person's care records showed that on one occasion they had waited seven hours and 30 minutes before they received the assistance they required. This person had a skin wound which meant they were at high risk of further skin damage. Staff told us they were unable to reposition people as planned as they didn't always have the time to do this. This meant people were at risk of developing skin damage as they did not always received their care as planned.

Accurate records of medicines administration were not maintained to ensure the provider could account for all the medicines at the home. We found inaccuracies in the numbers of stock recorded on people's medicines administration records against the actual numbers of medicines in stock. For example, we could not identify if three people had received their antidepressants as prescribed as there were too many of these left over in people's medicines boxes. We could also not be assured that people received their creams as prescribed as records did not show this. For example, one person who had skin damage was prescribed a barrier cream to protect their skin. Their medicines records only showed they had received their creams on

three of the 11 days leading up to our inspection. Staff told us they administered people's creams as prescribed, but people couldn't confirm this. Therefore these inaccuracies in medicines records meant people who used the service could not always be assured that they had received their medicines as prescribed.

Some people needed medicines to be administered on an 'as required' basis dependent upon their presentation and symptoms. Detailed protocols were not always in place to help guide staff as to when these medicines should be administered for each individual. This meant people were at risk of receiving these medicines in an unsafe and inconsistent manner. For example, one person had a protocol in place that stated their medicine should be administered when they displayed signs of agitation. However, the way their agitation presented was not listed. A nurse confirmed that this information was not sufficient. They said, "What I would interpret as agitation is not necessarily what someone else would". The risk of people receiving these medicines in an unsafe and inconsistent manner was increased due to the number of part time agency staff that were being used at the service as these staff would not know people's needs as well as the permanent staff.

We found people were not protected from the risk of infection because a clean and hygienic environment was not maintained. We saw that the environment on Spode unit was unclean. For example, floors, chairs and equipment were dirty. We asked staff on this unit if they thought the environment was clean. Responses included, "No, it's disgusting". And "No, I don't think it is". On Stafford unit we saw mattresses and bedding were not always clean. For example, one person's bed linen had been changed. The bed sheet was clean, but the duvet cover was stained with an unknown substance. When we checked the cleanliness of the person's mattress we found it was covered in dead skin which meant a clean bed sheet had been placed onto the mattress without cleaning it. This meant the environment at Stadium Court did not protect people from the risk of acquiring infections as a clean environment was not maintained.

We identified concerns with the way the risk of infection outbreaks were assessed. Staff told us one person who used the service was a carrier of bacteria that could cause an infection outbreak. Three of the four care staff we spoke with told us this person was isolated in their bedroom because of the risk they posed to other people. The fourth staff member told us the person could come out of their room, but would need to sit in an area of the home where they could continue to be separated from other people. They said, "I worry about them infecting other people". No risk assessment or care plan was in place to support the approach the staff were using with this person. The nurse we spoke with told us this person was not contagious. This meant the person was being unnecessarily isolated and staff did not understand how this infection could be spread.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite staffing telling us how they would identify and report abuse, we found that people were not protected from the risk of abuse and avoidable harm. One person's care records showed they had entered other people's bedrooms on at least seven occasions and attempted to or had started to undress people. This placed these people at risk of physical, sexual and emotional harm and distress. One person in particular had been the target of this behaviour on five of the seven occasions. No effective action had been taken to prevent these incidents from occurring and only one of the incidents had been reported to the local authorities safeguarding team as required. This meant people were not protected from the risk of abuse and avoidable harm and was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were also not protected from the risk of abuse and avoidable harm because effective systems were not in place to ensure staff were of suitable character to work with vulnerable people who used the service. We looked at staff files and found that the provider could not always evidence that safe recruitment systems were in place. For example, one staff member's file contained no references to show they were of suitable character to work at the service. The outcome of this person's criminal history check had also not been recorded, so again, we were unable to identify if they were suitable to work at the service. The manager told us he would request references for this person and ask them to show them their criminal history check.

When checks of staffs' criminal history checks came back positive, risk assessments were not always completed to manage any potential risks posed to people as a result of people's convictions. One staff member's records showed they had a significant conviction that could place people at risk of harm. The risk of harm to people was potentially high because of the type of shifts this staff member worked.

On the day of our inspection the home manager told us five of the staff members were temporary agency staff sourced from external providers. We asked how they could be assured that these staff members were of suitable character to work at the service. They told us they had asked for their profiles (information about their experience, training, and suitability to work with vulnerable people), but these profiles had not been sent to them. This meant we could not be assured that these temporary staff were suitable to work at the service.

The above evidence shows that people were placed at risk of harm to their health, safety and wellbeing through unsafe recruitment. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and we saw that staff were not always available to provide care and support when they needed it. Whilst we were in a corridor, we heard a person shouting from their bedroom for over 10 minutes. We went to them and found faeces over them and on their bedroom floor. They said, "I called for help, but no one came. I wanted the toilet". Staff told us this person could not use their call bell, but they checked on them every hour. There were no records to show hourly checks were being completed, and hourly checks would not have enabled staff to respond to this person's shouts for help, unless they shouted when their check was due. A visitor told us they often assisted their relative to access the toilet and change their clothing as staff were not always around. They said, "I get the impression there isn't enough staff. They can wait quite a while to go to the toilet so I take them myself".

Staff told us and staff rotas showed that safe staffing levels were not maintained. Staff and visiting health and social care professionals told us about an incident that had recently occurred where no nurse was on shift on Stafford unit. The rotas confirmed that two nurses were only on shift until 2pm. Staff told us when these nurses left, the deputy home manager came and worked on the unit for two hours, which left the unit without a nurse for four hours. Staff were told to call the nurse from Aynsley unit if they needed support. However, staff told us this would leave Aynsley unit without a nurse. "One staff member said, "I'm worried for the residents' safety". The manager told us that the deputy manager had requested cover from local nursing agencies, but no nurses were available. This meant that systems were not in place to ensure all units were staffed with the nursing staff required to keep people safe.

When we arrived on Stafford unit, staff told us they were two staff short. This meant the unit's staffing numbers had fallen well below the provider's safe staffing levels. We asked if any staff had called in sick which would explain the unsafe staffing numbers. However, staff told us no staff had phoned in sick. This meant safe staffing levels had not been planned for. The home manager told us this was an error on their part as they hadn't arranged cover for staff that had been moved to support another unit. They did however,

arrange for cover later that morning. This showed that effective systems were not in place to ensure safe staffing levels were consistently maintained.

Staff told us that they were not always able to provide people with the full support that they needed. One staff member said, "We can't get round to people who need turning bang on four hours with the staff we've got. It means they are going to get sores". Another staff member said, "Because most people need two staff, we can't get to them on time". We asked this staff member what risk this might pose to people. They said, "If they have been incontinent their urine or faeces could burn them". People's care records confirmed that they did not always receive the support they needed when they needed. For example, people who required assistance to change their position every four hours did not always receive this support on time. This placed people at risk of avoidable harm.

We also saw that staff were not effectively deployed. For example, on one unit, we saw three staff members leave the unit for their break at the same time. This left the unit short of staff which meant staff were not in a position to promptly meet people's needs. The manager told us he would address this issue.

The home manager told us they recognised that staffing levels were not adequate or safe and they told us staffing levels would be immediately increased on at least two of the units at the service.

The above evidence shows that staff were not always available to keep people safe or meet people's care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inadequate and unsafe staffing levels also meant people's dignity was not consistently promoted. We saw some people's clothes still had their lunch down them just before tea time. Staff told us they hadn't had time to change people's clothing. We also saw people's requests to access the toilet were not met in a timely manner. On one occasion, we saw this resulted in the person being incontinent which compromised their dignity. This meant that people's dignity was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager, but a new home manager had been working at the home for approximately two weeks. No unit mangers were working on the unit's we inspected on the day of our inspection. Staff told us and staff rotas showed that unit mangers often worked on the units in a clinical role rather than a management role. This meant the management structure at the home was ineffective as unit managers could not always carry out their management responsibilities. For example, staff told us they didn't receive supervision from their managers on a regular basis because of this. Supervision is a process where staffs' competencies and development needs are assessed and managed.

Records showed that the provider's daily walk around audits (daily checks of risks to people, wounds etc) were not being completed daily by the management team as planned. The manager told us they couldn't find any of these audits for November 2016 and they did not know why they had not been completed. This meant the provider's monitoring systems were not being completed as planned.

Effective systems were not in place to ensure risks to people's health, safety and wellbeing were assessed and planned for. For example, one unit had workmen present completing improvements. We saw ladders were located in the corridors where people's bedrooms were located. Staff were not supervising these corridors which meant there was a risk people could hurt themselves by falling over the ladders. Some people who lived on this unit were very mobile and their care records showed they were at high risk of falling. Staff confirmed no risk assessment had been completed to assess and plan for the risks associated with the workmen being on site.

Effective systems were not in place to ensure action was taken to manage people's risk of injury and harm from falling. We found multiple examples where completed incident forms recorded that people's falls care plans and risk assessments were to be reviewed following their falls. We saw this agreed action was not always completed as planned. There were no effective systems in place to enable the manager or provider to check these actions had been completed to promote people's safety.

Effective systems were not in place to check that people had received their planned care. For example, re-positioning charts were not being checked to identify if people were supported to change their position as frequently as planned. One staff member told us they were responsible for this task on their unit. They said, "I can't always check the turn charts because there is usually only one nurse on duty. When there is only one nurse on duty, I have to help give medicines which takes up a lot of my time". As a result of this people had received and were at risk of continuing to receive unsafe care.

Care plan audits were not being completed effectively as the content of people's care plans was not checked regularly. For example, management records showed that only 12 people's care plans were reviewed in November 2016 across the site. This meant some of the recording concerns we had identified had not been identified by the manager or provider. For example, care records also showed that accurate records of people's skin damage were not recorded in accordance with professional guidance. The National Institute for Health and Care Excellence (NICE) Pressure ulcers: prevention and management guidance

states that all pressure ulcers should be classified using a validated classification tool. We saw that wound charts did not always classify people's pressure ulcers as required. For example, one person's wound chart recorded their skin damage as a skin break, but a nurse told us the person had a grade two pressure ulcer. This meant information was not clearly recorded to enable staff to monitor people's wounds for changes. This placed people at risk of harm as deteriorations in their wounds may not be promptly identified and acted upon.

Many of the staff we spoke with told us they had raised concerns about the quality of care with the management team and provider. One staff member said, "We had a meeting recently where we all said we didn't have enough staff. Nothing was done though". Another staff member said, "We keep saying there aren't enough staff. The new manager has said he will try and get more, but we haven't had any more so far". Rotas showed that staffing levels had not been changed in response to the staffs' feedback. As a result of this some staff told us they were reluctant to approach the management team as they did not think they listened to or acted upon their concerns.

The above evidence shows effective systems were not in place to assess monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of at least seven incidents of alleged abuse as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of at least seven incidents of alleged abuse as required under our registration Regulations.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not consistently promoted.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people consistently received their care in a safe manner.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse

Treatment of disease, disorder or injury	and avoidable harm.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess monitor and improve quality and manage risks to people's health and wellbeing.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were placed at risk of harm to their health, safety and wellbeing through unsafe recruitment.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available to keep people safe or meet people's care needs.

The enforcement action we took:

We served an urgent Notice of Decision to restrict admission and re-admissions to the service. The service was placed in special measures.