Anexas Care Limited

Stanholm Residential Care Home for the Elderly

Inspection report

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

Summary of findings

Overall summary

We inspected Stanholm Residential Care Home for the Elderly on 19, 24 and 26 October 2017 and the inspection was unannounced. Stanholm Residential Care Home for the Elderly (from here on in this report referred to as Stanholm) provides care and accommodation for up to 26 older people, some of whom have dementia. At the time of our inspection there were 22 people living at Stanholm. Stanholm is located in Edenbridge, in Kent, with 23 bedrooms over three floors, serviced by a lift. At the time of our inspection there were three shared bedrooms, two of which were being shared. Stanholm has its own gardens, a conservatory/lounge area, a quiet lounge and dining room.

The service had a registered manager in post. 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 2008 and associated Regulations about how the service is run.

We previously inspected this service on 29 May and 01 June 2015 where we found breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 and we rated the service as Requires Improvement with a rating of Inadequate in the safe domain. These breaches of regulation related to safeguarding people, safe care and treatment, maintenance of premises, good governance, safe staffing, consent, person centred care, and acting on complaints. The provider sent us an action plan stating that they would address all of these concerns by July 2015. We further inspected the service on 25 and 26 August 2016, and found that improvements had been made and nine breaches had been fully met. However, there were ongoing breaches of regulations relating to consent and person centred care. We also found a new breach of regulations in safe care and treatment. The registered provider sent us an action plan stating that they would address all of these concerns. At this inspection we found that although some improvements had been made, the registered provider continued to breach the regulations relating to safe care and treatment, consent and person centred care. We also found seven new breaches of regulations in relation to nutrition and hydration, dignity, display of ratings, requirements relating to the registered manager and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were not being managed safely. Staff who were trained to give medicines did not have a check of their competence to administer medicines safely, stocks of one controlled drug were not accurate, the administration of creams was not being managed safely and not all people received their medicines on time.

Falls and other risks were not being managed safely. Risk assessments did not contain control measures to mitigate potential hazards and had not been updated following incidents. The auditing of falls had not been effective.

People were not supported to have maximum choice and control of their lives and staff did not support

them in the least restrictive way possible; the policies and systems in the service did not support this practice. For example, people had not been assessed to determine whether they had the capacity to make a decision. The requirements of the Mental Capacity Act 2005 had not been met.

Not all people's healthcare needs were being met in a timely manner. One person had not been eating due to a medical condition. Staff had recorded this but had not taken any further action despite the person going 44 hours without food.

People's dignity was not always upheld. Some practices around mealtimes were not empowering, and one person was left to watch a film in a chair where they could not see the television screen.

Activities were not person centred, varied or frequent enough and people who were at risk of isolation had not been evidenced as being engaged in activities. Care plans were not personalised and contained contradictory information. Daily care reports were focused on physical care tasks and not insightful enough to give a clear picture of the care people had received and their overall wellbeing.

Audits were not effective in highlighting the shortfalls in service delivery found in this inspection. Audits and systems to monitor the quality of service had not generated action plans or driven improvements.

People were kept safe from abuse at Stanholm. Staff knew how to report any concerns. We noted that the local authority safeguarding information was out of date. We have made a recommendation about this in our report.

Staffing levels were adequate to meet people's needs and keep them safe. The rota used to record hours provided only included care workers and did not contain the hours worked by the management team, cleaner or cook. We have made a recommendation about this in our report.

Staff told us that they had the training they needed to carry out their roles and where needed they had received additional training, although we found some training was not effective such as around the Mental Capacity Act 2005. Supervisions and appraisals were provided to staff but were not planned. We have made a recommendation about this in our report.

People told us that they received adequate food and drink to maintain good health although we found one person had not received adequate nutrition. People's special dietary requirements, such as diabetic friendly, were known to the cook and staff.

People were supported by staff that had got to know them well and people told us that they liked their staff. Some good interactions were observed throughout our inspection, such as staff sitting and talking with people as equals. People could have visits from family and friends whenever they wanted.

Complaints had been dealt with effectively in line with the complaints policy. The complaints procedure did not evidence who people should talk to if they were not happy with the complaint response, which should include the local authority and Local Government Ombudsman. We have made a recommendation about this in our report.

There was an open, transparent culture in the service. The management team had positive relationships with the care staff and knew people well. The registered manager took an active role within the service.

The overall rating for this service is 'Inadequate' and the service is therefore in '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.

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.

People's medicines were not being managed safely. Some people did not have clear information recorded regarding allergies to medicines and stock control of certain medicines was not accurately recorded.

Risks were not consistently being managed to reduce the potential for hazards. Some risk assessments did not have control measures and people at risk of falls were not being assessed and managed safely.

People were protected against abuse by staff that had the training and confidence to report safeguarding concerns.

There were sufficient numbers of qualified staff deployed on each shift to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act 2005 (MCA) were not consistently applied in practice.

People at risk of malnutrition or dehydration were not always closely monitored. People had choices of food at each meal time.

People had access to a wide range of healthcare professionals when they needed them.

Staff received appropriate training to give them the skills and knowledge required to provide care although not all training was effective.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always upheld and some practices

around mealtimes and interacting with people require improvement.

Staff knew people well and used the information about people to effectively support them and build up caring relationships.

People's independence was encouraged and families were always welcomed to visit the service.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving a person centred service. Activities were not varied or individualised and people at risk of isolation had long periods with little or no stimulation.

Care plans were not personalised and daily records of care were task focused, repetitive and did not reflect the actual care people received.

Complaints were used as a tool to improve the service and had been resolved in line with the registered provider's complaints policy.

Is the service well-led?

Inadequate

The service was not well led.

Quality audits had not been effective in highlighting shortfalls in service delivery found at this inspection and had not generated action plans to drive improvement. We also found that the services CQC ratings had not been displayed.

The registered manager was an active presence in the service and people, staff and relatives spoke highly of their leadership style. However, the registered provider had continued to fail to comply with the regulations as set out in the Health and Social Care Act (Regulated Activities) Regulations 2014.

The culture of the service was open and warm and people felt at home at Stanholm. The staff team were supportive of each other.

Stanholm Residential Care Home for the Elderly

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 is 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.

This inspection took place on 19, 24 and 26 October 2017 and was unannounced. The inspection was carried out by two inspectors, two experts by experience and a medicines inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As some people who lived at Stanholm were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, six care staff, nine people and five people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at 11 people's care plans, medication records, risk assessments, accident and incident records, maintenance records, complaints records, four staff files and quality audits that had been completed.

We last inspected this service on 25 and 26 August 2016 where we rated it as Requires Improvement.

Inadequate

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at Stanholm. One person told us, "Staff come quickly if you press a bell – no more than three or four minutes, sometimes quicker than that. During the day they come at least twice to see how you are and at night that door opens and they look in to see you are OK; this makes me feel safe." Another person said, "I do feel safe. If there is a problem they will respond to the buzzer quickly." A third person commented, "I feel safe living here. I feel safer than when I lived at home on my own." A relative told us, "X's been unwell and they've looked after him very well. They answer any questions and ring if he's poorly." A second relative commented, "Recently mum's had health problems and they've been so good and have got her a separate recliner chair to put by the door to get air in to cool her down: they've gone over and above and they're watching her." However, despite these positive comments we found examples of care that were not safe.

At our previous inspection on 25 and 26 August 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that some medicines had not been stored safely, and medicines were not being recorded or risk assessed appropriately. At this inspection we found that medicines were being stored safely but recording and risk assessment of some medicines was still poor and there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our previous inspection we found that the application of creams was poorly documented and that people who administered their own medicines were not always assessed appropriately to ensure they were safe. At this inspection we found that one person was prescribed two creams to be applied twice daily. However, staff had not recorded the administration of these creams. This meant that staff could not be assured that the person had received their creams. Three people were administering their own medicines. We saw one person's self-administration assessment had been completed in April 2017, but did not have a review date. Staff were not able to tell us how often, or when these were reviewed to ensure self-administration continued to be appropriate. Weekly risk lists stated that two people self-administering were at risk of refusing medicines or of overdosing. The lists stated that staff should check people regularly. However, checks and monitoring had not been carried out and staff did not ask, or document, if a person had taken their medicines. This left people at risk of harm from inappropriate use of medicines.

Controlled drugs (medicines requiring special storage and record keeping) were stored securely. However, quantities were not checked weekly in line with the home's policy. We saw one record that had an incorrect quantity documented three weeks earlier and this error had continued as staff had not counted the stock each time the person had been given the medicine. We raised this with the registered manager who made a new entry in the controlled drugs book to explain the incorrect quantities.

Not all training for staff to administer medicines to people was effective. Staff who handled and administered medicines to people had received some training from the community pharmacy. However, staff had only received a competency check as part of their training and not an additional observed competency check of staff practice as they were actively administering medicines to people. The home's

medicine policy was not being followed by staff and had not been reviewed. For example, the policy said that any 'homely remedies' given to people must be agreed by their GP. Homely remedies are medicines that are bought over the counter to treat minor ailments such as a headache. We saw that staff had recorded that a homely remedy was given to one person, but this had not been agreed by their GP. The policy lacked detail about what homely remedies were kept and there were no written procedures for staff to know when they could be given or how to record them. Some medicines were prescribed to be given on a 'when required' basis. However, there was no guidance for staff to follow about when a person might need the medicines. Staff did not record that 'when required' medicines had been offered to people. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. The absence of PRN protocols meant the provider was unable to embed a consistent approach to the management and administration of PRN medicines.

We looked at medicines records for nine people. The home had not contacted the GP to review the medicines for one person who was receiving palliative care following a deterioration in their condition. This meant that the person was being administered more medicines than necessary and some doses were not appropriate. We raised this during our first day of inspection and staff did contact the GP and the medicines were stopped. One person's records had inconsistent information regarding their allergy status. For example, one document stated they were allergic to penicillin and another stated they had no known allergies. This meant that the person was at risk of having an allergic reaction if they were prescribed penicillin. Another person's GP summary stated they previously had an adverse reaction to two medicines, but these were not documented on the medicines administration record (MAR). We observed staff administering medicines to people in a caring manner. The MARs folder did not include photographs to help identify people, although staff knew people well. The process was methodical and staff signed MARs after medicines were given.

The failure to ensure the proper and safe management of medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being protected against risks and action had not been taken to prevent the potential of harm. Risk assessments failed to mitigate the potential hazards. There was a weekly risk assessment that covered areas ranging from falls to skin integrity. The assessment only scored whether the risk was deemed to be high or low. Where risks had been scored high there were no actions or changes recorded to reduce the risk. Falls were not being managed safely. Several people living a Stanholm had a history of falls or had recently fallen in the service. For example, we noted that one person had a history of falls. There had been three falls in the past year which had required hospital treatment, the latest of which was in October 2017. This person's care plan had stated on 17 August 2017 that they 'had lost confidence and mobility due to recent falls'. The action required section stated, 'I will ring for assistance when needed and will try to rebuild trust and confidence'. The care plan gave no indication of how this was to be achieved. There was no information about injuries caused or how, where and why they occurred. We noted there was contradictory information in this persons care plan regarding falls. For example, the latest weekly risk assessment stated the person was at high risk of falls but their pressure area assessment of 8 October stated their impaired mobility was low. There was also a falls prevention checklist in the care plan but this was generic in nature and was the same in all the care plans we looked at. We did not find a care plan concerning falls prevention for this person in the documentation we looked at.

Another person was marked as a high risk of falls on the weekly risk assessment. They had four falls from May 2017 onwards. However, the falls prevention checklist had last been updated in April 2017 meaning that the person had fallen four times without the prevention checklist being updated. The persons care plan mentioned a pressure sensor mat [used to alert staff when a person has got up from their bed] being in their

room, but this was not in the falls prevention assessment or risk assessment. In addition it was noted that the person had been known to unplug the pressure mat but there were no checks of the mat recorded and no risk assessments to reduce the likelihood of his happening. It was noted that the same person had been seen by a medical professional for a urinary tract infection [UTI]. UTI's can cause people to become disoriented or confused and can be a cause of falls. The person's care plan, falls risk assessment, and falls prevention checklist had not been updated following the diagnosis of a UTI and action was not being taken to reduce the risk of a further infection.

People were not being kept safe form the risk of falls and falls were not being managed effectively to ensure peoples safety. The registered manager had completed a falls audit every month. However, the audit only described people's falls. There was no analysis, action planning or any meaningful information to assist in falls prevention. We checked the information on the audit and saw that for September 2017 there was an entry stating 'no further action required' signed by the registered manager. However, we noted that one person had fallen twice in September 2017. One fall had resulted in the person being taken to hospital. The same person had also been recorded as having fallen twice in July 2017. We checked the persons care plan with the registered manager and found that their falls risk assessment had only been updated in April 2017 and September 2017. There had been no update following the two falls in July. This person's falls prevention checklist had also not been updated since April 2017 despite the recent falls and admission to hospital. In addition we found that another person who had a history of falls and had recently fallen in the service on multiple occasions was missing from the monthly analysis of falls for two months during which they had falls. We raised this with the registered manager and were told that it was an administrative error.

The management of other risks was not safe and care plans did not always contain detailed information about people's care needs and actions required in order to provide safe care. For example, we noted one person had been identified in their weekly risk assessment as being at high risk of 'handling injury'. This meant the person was vulnerable when being assisted by staff to stand, sit or lie down. We noted the 'handling assessment' contained very little detail. It only stated that two 'nurses' were required when the person was walking, transferring and going to the toilet. In the 'details' section, the only information contained was 'X is chair bound'. The assessment was not personalised and gave no information to staff about what the actual risks were and what actions staff should take to avoid them. Another person's handling assessment stated they required assistant from, '1-2 nurses' for transfers from chair to wheelchair. However, their daily care plan noted they could transfer themselves to a chair without staff assistance. We found a recent assessment from the local authority about the same person that contained detailed information on how the person's illness impeded their movement. This relevant information had not been included or considered in the handling assessment or care plan.

The failure to keep people safe from harm is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Environmental risks were being managed effectively through regular monitoring and checks conducted by the registered manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. Regulatory risk assessments were completed to reduce hazards around Control of Substances Hazardous to Health (COSHH) and food safety. The cook was using the Food Standards Agency 'Safer Food Better Business' scheme to ensure food safety. Fire protection equipment was regularly checked and serviced by an external company. Fire safety checks were happening and staff had received training in fire safety. The service held an emergency contingency plan that was comprehensive, regularly reviewed and updated.

At our previous inspection on 25 and 26 August 2016 we made a recommendation that the registered

manager sought guidance on effective communication after a potential safeguarding incident was recorded incorrectly. At this inspection we found improvements had been made. During our inspection there had been a potential safeguarding incident. The registered manager had spoken to staff who witnessed the incident, completed an incident form, and informed us that a safeguarding referral would be made to the local safeguarding adults team.

The registered provider had a copy of the local authority multi-agency safeguarding adult's policy, protocols and guidelines. However we noticed that this was not an up to date version and did not contain reference to the newer definitions of abuse or the latest reporting procedures. We brought this to the attention of the registered manager who told us that they would update the policy. The registered provider had a safeguarding policy and displayed information by the front door and the office door showing staff and visitors how to report abuse during office hours, out of hours and in an emergency.

We recommend that the registered manager ensures updated policies and procedures for reporting safeguarding incidents to the local safeguarding adults team are available to staff.

There were enough staff employed and working each shift to keep people safe and meet their needs. The registered manager ensured that four staff were deployed in the mornings and three staff worked each afternoon. At night times there were two night workers. In addition to care workers the registered provider employed a cook and a cleaner. We checked the staff rota for four weeks prior to our inspection and saw that a team leader was allocated to work each shift. We saw that additional staffing had been allocated to some shifts to proactively cover a potential problem. We asked the registered provider if there was a dependency assessment used to determine staffing levels but one was not used. The registered manager informed us that they held an informal meeting with the team leader at the end of each week to discuss staffing levels and whether anyone requires any one to one staffing. These meetings were not recorded. We noted that the staff rota only included direct care staff, so did not include the registered manager, cleaner and cook's hours worked.

We recommend that the registered manager implements a rota system to capture the hours worked by all employees of the service and demonstrates a systematic approach to how they review staffing numbers.

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for four staff members. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including professional and character references, job descriptions, contracts and training certificates in staff files.

Inadequate

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "It is as if the staff have been selected as they are so nice." Another person told us, "The staff are pretty helpful. They know what they're doing." One person's relative told us, "Yes I think the staff know what to do: they come rushing in an emergency and lay mum flat and call the ambulance if the seizure is serious, so yes, they know what they're doing." Another person's relative commented to us, "They always seem to know what they're doing and they give meds when he refuses by going back to him: [before he deteriorated] he said the staff were lovely and knew what they were doing." However, despite these positive comments we found areas of care that were not effective.

At a previous inspection 29 May and 1 June 2015 we found a breach of Regulation 11 of the Health and Social Care Act as staff and management did not understand the requirements of the Mental Capacity Act 2005 (MCA) and assessments of people's capacity to make decisions had not always been carried out. At the next inspection on 25 and 26 August 2016 we found that some improvements had been made. Staff and management had had training and demonstrated a good knowledge of the MCA. Assessments of capacity had been carried out but the registered provider had not ensured that the requirements of the MCA were put in to practice when obtaining consent. This was a continuing breach of the Regulation. At this inspection we found that the registered provider had not made the required improvements and continued to breach this regulation.

The 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People's rights had not been protected because the registered manager had not acted in accordance with the Mental Capacity Act 2005. Several people we spoke with were unable to communicate their needs, and therefore would be unlikely to be deemed to have the capacity to make certain decisions. However, none of the care plans we looked at contained mental capacity assessments in relation to specific decisions, such as the decision to live in the home under 24 hour supervision. We asked the registered manager where the MCA assessments for people were and were told that there were none. We asked why there were no MCA assessments and the registered manager did not know why. This meant that people could be having their freedom restricted unlawfully.

Peoples care plans did not clearly record whether they lacked capacity to make certain decisions. We noted that care plans contained confusing and contradictory information. One person had bed rails raised on their bed as a safety precaution. This person's capacity to make a decision about using the bed rails should have been assessed under the MCA but had not been. Under the Mental Capacity Act (MCA) 2005 Code of Practice,

where people's movement is restricted, this could be seen as restraint. Bedrails are implemented for people's safety but does restrict movement. Where people could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom for example the use of bedrails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. We asked the registered manager if a DoLS application had been made for the person in respect of the restriction by using bed rails and were told, "It was suggested but it's not been done yet." We also saw the person had a do not attempt resuscitation (DNAR) form in their care plan, but this was not completed fully as it did not state whether they had capacity to decide whether they wished to be resuscitated or not. The DNAR indicated that the person's relative had decided not to attempt resuscitation. We discussed these two decisions with a team leader and were told that the person had consented verbally to the use of bed rails as they had capacity to make day to day decisions. However, when we discussed the DNAR with the team leader they agreed that the DNAR suggested that the person lacked capacity to make decisions around restrictions. Because there was no MCA assessment care workers could not know if the person was able to consent. We spoke with the person and found they were confused and disoriented to place and time. A bed rails assessment had been completed but this did not assess the person's capacity to consent to the restrictions. The registered manager had submitted a DoLS application for another person. However, the DoLS application did not demonstrate that a mental capacity assessment had been completed and the person was unable to consent to the restriction themselves. The reason for referral was given as their need for assistance with personal care. The reason why the person's liberty was to be restricted was given as anxiety and depression. This same person was also sharing a room and had signed a consent form to state they were happy to share their room. All four people currently sharing rooms had signed consent forms but it was unclear if these people had capacity to sign the form or not due to conflicting information in their care plans. Subsequent to our inspection to the registered provider assured us that three of the four people had capacity. However there was no MCA assessment completed for the person that may lack capacity around the decision to share a room.

The failure to put in to practice the requirements of the MCA is a continued breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Healthcare needs were not consistently responded to in a timely manner. We found a serious and significant failing for one person where their health needs were not being met. One person was struggling to eat their meal. We asked a team leader if the person required assistance to eat and were told, "X hasn't been eating well recently." There were food and drink charts and they showed that for three days from lunchtime on 21/10/17 until lunchtime on 24/10/17 the person had only eaten a slice of toast, a biscuit, half a sandwich and a couple of bites of another biscuit. Within this timescale the person went 44 hours without eating food. There had been no action recorded when the person repeatedly refused offers of food. We asked the registered manager what action had been taken and were told that they had contacted the persons' GP 10 days earlier who had diagnosed a chest infection and prescribed medicine to counter this. The registered manager told us, "We were going to contact the GP as X is confused. We were going to get the GP to review the meds." However, no action had been taken. We advised the registered manager to contact the persons GP and investigate whether dietary supplements could be explored. Other charts for fluid intake only recorded if a drink was given and did not accurately record how many millilitres of fluid the person had drunk. This meant that staff could not be sure how much fluid people had drunk or when they needed to have their levels of hydration monitored.

The failure to review and take appropriate action to meet people's nutrition and hydration needs is a breach of Regulation 14(1)(4)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. One staff member told us, "The district nurse comes round very regularly and peoples' GP's visit the same day we call them. All the services are very local here and most of the staff are first aiders." People had a health action plan which described the support they needed to stay healthy. Stanholm involved a range of external health and social care professionals in the care of people, such as dieticians, community nurses and speech and language therapists. We also spoke with two visiting health professionals during our visit. They told us that staff were knowledgeable about the people they were caring for. They said that staff referred to the health professional appropriately and followed advice and guidance given. They felt the home was a caring place.

People's dietary needs were documented and known by the cook and staff. The home's cook kept a record of people's needs, likes and dislikes. The cook and the registered manager had both been trained to level 2 food safety. The kitchen and dry stores area was clean and tidy and the registered provider's food policy was in place. People's preferences were displayed and staff knew which people had dietary restrictions in place. For example, one person had diabetes so was offered fruit for dessert instead of jam tart. People's preferences around drinks and snacks were displayed in the kitchenette area off of the main lounge. We saw that it contained information about what type of vessel people drank from, if they preferred tea or coffee, if they took sugar, and which breakfast choices they preferred. We received mixed feedback about the food at Stanholm. One person told us, "The food is not all that. Same old stuff and it does not really change. It's not really hot and we do not have a proper chef like we use to." Another person told us, "The food could be better. We need more variety. For afters we only seem to have a choice of jelly, fruit or mousse: I want proper puddings." Other people told us, "The food is very nice, and in the evenings they make you a coffee; if you wanted it you could have it" and "the food is all well-cooked." We asked how feedback around food was gathered and we were told that the cook goes round and speaks to people. However, we could not see that this was recorded or that any action had been taken to respond to feedback, for example if one person liked their vegetables cooked well or another liked them al dente.

We recommend that the registered manager implements an audit of people's preferences for meal times and records any changes in people's care plans.

Staff told us that they had the training they needed to carry out their roles. One staff member told us, "I've been sent on loads of different courses. Catheter care was really helpful as two people here have catheters." We looked at the provider's staff training matrix and examined training certificates for staff members. We noted staff were able to access training in subjects relevant to the care needs of the people they were supporting. The provider had provided training in areas including infection control, moving and handling people and fire awareness. However, only one had completed health and safety training in the past year. Of the other training on offer, only one person had completed dementia care training in 2017 and none had completed catheter care training in that time. All relevant staff had completed training in end of life care and the MCA

People were supported by staff who had supervisions (one to one meeting) with their line manager. Supervision and appraisal sessions had been held with all staff whose files we looked at. Supervisions and appraisals were organised in a 'cascade' system, where team leaders supervised care staff. However, the provider did not make use of a supervision matrix or tracker, so were unable to demonstrate to us an ongoing, systematic approach to staff supervision. The provider did convene staff meetings on a monthly basis. However, these were only attended by the manager and team leaders. We were told information from these meetings was disseminated to staff subsequently, as it was a small home and most day to day issues were discussed at the time.

We recommend that the registered manager reviews staff training and planning of supervisions and appraisals to ensure they are provided in line with staff need and best practice.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that they found the staff team at Stanholm to be kind and caring. One person told us, "The staff are excellent. They are very caring people." Another person commented, "I think the world of the staff: we have a laugh and I wind them up." A third person said, "I fell on my feet here, the people have been absolutely excellent they do everything they can to help you and even more than is necessary. They do everything you want, for example if I need new batteries someone will sort them out." One person's relative told us, "Yes the staff are caring. When I was away for two weeks in summer and was worried she wouldn't recognise me when I return X's key worker went through family photos and reminded X who we were." A second relative commented, "Yes they always seem very caring; they bring biscuits with morning coffee and invite us to have tea and cake in the afternoon." Despite this positive feedback we found some areas of care that required improvement.

People's dignity was not consistently upheld. We noted staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. There was a calm and inclusive atmosphere in the home. However, there were instances where people were treated in a less than respectful manner. In the afternoon, we noted a member of care staff selected a film for eight people sitting in a communal area to watch. We found no indication that people had chosen this film for themselves. Subsequent to our inspection the registered provider told us that the films were selected as appropriate for people living with dementia. After the film started, we noted staff members left the room; there was no staff presence in the room for half an hour. When a staff member returned to offer cups of tea, they found all of the people sleeping or dozing with no-one watching the film. On another occasion a person was sat next to the TV so they were unable to see it. The seat appeared to be the person's 'chair'. The persons' 'This Is Me' section of their care plan referenced their favourite chair in the lounge. We noted the person was also sat in this chair on the previous day of our inspection and the daily care notes for that day recorded that the person watched TV in the am and pm entries. This was despite the fact that the person could not see the TV properly. Staff did not try and move the TV or the person or provide a different activity for the person and they had been left for extended periods of time watching a TV they could not see. This was not caring or respectful support. During one of the mealtimes we observed practices that did not uphold people's dignity. One person asked for assistance cutting their food. A staff member did not engage with the person and hastily cut up the dinner with a spoon and walked off leaving the person looking upset. Another staff member asked a person, "You alright X?" The person responded, "I have had enough" but the staff member did not ask any questions and the persons plate was removed. Another person asked for custard with their desert but was told, "No custard today only cream." The staff member did not try and get the person some custard from stores or re-assure them they could have some later. We noted staff did not have access to equality and diversity or respect and dignity training. By the end of the inspection process the registered manager confirmed that equality and dignity training had been booked.

The failure to protect people's dignity is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed care and support given to people throughout the day. We observed some good interactions

between people and staff who consistently took care to ask permission before intervening or assisting. We saw that some people were had soft toys that brought comfort to them and staff ensured that people had these with them when sitting in the lounge. There was a good level of engagement between people and staff. During one afternoon the cook had made 'rock cakes' so one staff asked a person if they wanted to help get them out of the oven and hand them round to people. The person was happy to do this and engaged the staff member in conversation. Staff supported the person to walk round people and offer them a warm cake from a silver plate. The person enjoyed this interaction and encouraged other people to take one by saying, "Are you sure you won't take one, they're warm and taste lovely." Consequently all people enjoyed eating one of the cakes with their afternoon cup of tea. Staff told us that they were encouraged to promote people's independence. One staff member commented, "From the first day I started I was told to encourage residents' independence even if it's just someone washing their face during a bath. Some people can do most things and just need a little assistance with washing."

Staff members had got to know people well and built up meaningful relationships that were based on trust and respect. One staff member commented, "X likes to sit in his room and not come out but I manage to get him in to the lounge. I've managed to get him in to his wheelchair and took him to an orchard which he really liked. Because of our close relationship he likes me to make his hot chocolate at night and will ask me to shower him." Another staff member commented, "One person has no family and visitors and has a photo of his old German shepherd dogs in his room, so I did a drawing of them for him and he was so happy when I gave it to him he cried." We saw that the person had this drawing of their old dogs next to them in the lounge on the days of our inspection and enjoyed talking about the dogs to us.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us that Stanholm was a service that responded to people's needs. One person told us, "This is my room. My own space. I can do what I want up here." One relative commented, "Yes all the ladies have different needs and they respond uniquely to mum's special problem." Another relative said, "They [staff] don't care for everyone in the same way: they talk to dad like he was still well." Despite these positive comments we found areas of care that were not consistently responsive.

At a previous inspection 29 May and 1 June 2015 we found a breach of Regulation 9 of the Health and Social Care Act. We found that some people were at risk of becoming socially isolated with limited activity to stimulate them in order to meet their needs and preferences. At the next inspection on 25 and 26 August 2016 we found that improvements had been made. People took part in activities that were suited to their choice and preferences, and the registered manager told us that an activities coordinator was to be appointed. However, structured activities took place only once a day, and there was limited choice for people with mobility problems. This was a continuing breach of Regulation 9 of the Health and Social Care Act. At this inspection we found that the required improvements had not been made and the registered provider continued to breach this regulation.

Some people were at risk of social isolation at Stanholm. One person was being cared for in their bed and staff had completed an activity record to capture every time they interacted with the person. We saw that for October 2017 13 of the 23 days we looked at had no entry recorded to state that anyone had interacted with the person. Of these 13 gaps there were 3 occasions where there had been a two day gap without any activity or interaction recorded on the charts. We found an older record for August 2017 covering the period from 14/08/17 to 31/08/17. In this 18 day timeframe we found 6 days with nothing recorded. Another person had been assessed as having a history of depression and suicidal thoughts. Their activities sheet showed only seven entries of social activities or meaningful occupation since November 2016. We asked the registered manager what was put in place to ensure that the person was not isolated or depressed. The registered manager told us, "X is offered all activities. All we can do is monitor X's moods and we've offered outside activities." We spoke to the person and they told us a specific activity they used to love doing. We could not find this interest referenced in their care plan.

We noted there was little provision of meaningful occupation for people at Stanholm. During our inspection we noted long periods of time where most people were either sitting alone, in communal areas or in their rooms. People told us they wanted more to do. One person told us, "There's not a lot going on in the home. A bit of music a few days a week. They just sit around not doing much. It is boring here." Another person commented, "There is not much to do. I spend most of my time in the room. They try to get me involved but nothing is going on that I want to do. Sometimes [another resident] sits in my room and we watch TV together." A third person said, "There is not much to do. I am lucky as my family visits a lot and they take me out. It would be so nice if we went on outings. I would like to go to the seaside in the summer. The last outing we did was last Christmas. I thought I would have gone out more when I moved here." One relative told us, "Activities: that can be looked in to. I know that on certain days there's nothing for them to do." A second relative commented, "Probably they could do with more things happening. Mum goes to a day

centre on a Thursday so they're out all day: they could do more."

The activities records in the care plans we looked at contained, in some cases, less than one activity recorded per month. Even then, we noted items such as chiropody visits were included as a social activity. For example one person had six activities recorded in 2017: two of these entries were for a takeaway meal and having their nails done. Another person had only four activities recorded in 2017 and two of these were meals in the service. There was an activities board displaying what was on offer for the week commencing 23/10/17. On Monday there was listening to the radio in the afternoon; on Tuesday there was an art and craft activity in the morning; on Wednesday there were games in the afternoon; on Thursday there were chair exercises in the morning; on Friday there was a hairdresser in the morning and pampering in the afternoon; on Saturday there was a film in the afternoon and on Sunday there was a religious service in the morning. There were no evening activities planned for the week and six out of 14 day sessions were blank. A care worker had been identified to take on the responsibility for co-ordinating activities in the service. However, they had found it too difficult to do both activity co-ordinator and care roles. We asked the registered manager what has been done since the care worker stopped doing activities and were told, "To be honest it's what we can do in-house. We've identified it's not good enough and know we've got to address it further."

The failure to provide suitable activities and to ensure that people were not at risk of becoming socially isolated with limited activity to stimulate them in order to meet their needs and preferences is a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's needs were not consistently reviewed as required and the care plans we reviewed did not contain evidence of people or their relatives being involved in developing their care plans. One person told us, "I have never met with anyone to go through my care plan." Another person commented, "I am not involved with my care plan. No one goes through it with me." A third person said, "I have not had any reviews of my care. They do not go through my care plan." We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans and risk assessments were reviewed regularly by staff but they were not signed by people, relatives or representatives. People or their representatives had no regular and formal involvement in ongoing care planning or risk assessment. Consequently, there were limited opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately. We spoke to the registered manager about this and were told that care plans were reviewed by talking to people but this was not recorded.

Care plans were not personalised and failed to detail daily routines specific to each person. For example, we noted one person had been identified in their weekly risk assessment as being at high risk of 'handling injury'. This meant the person was vulnerable when being assisted by staff to stand, sit or lie down. We noted the 'handling assessment' contained very little detail. It only stated that two 'nurses' were required when the person was walking, transferring and going to the toilet. The home is not registered for nursing care so should not refer to the provision of nursing staff in the care plan. In the 'details' section, the only information contained was 'X is chair bound'. The assessment was not personalised and gave no information to staff about what the actual risks were and what actions staff should take to avoid them. Another person's care plan stated that staff would help them with all aspects of their personal care but did not say how this was to be achieved. For example, did the person prefer a bath or shower, could they shampoo their own hair etc. This person had recently become unwell and was experiencing a reduced appetite. Their care plan had not been reviewed and updated to reflect this. Several places in the care plan referenced that the person ate well, that the person was in good health and had no health issues and had no dietary needs. Another person had been assessed by the local authority prior to coming to Stanholm and there had been several areas of need identified in the assessment such as the person being at risk from

urinary tract infections (UTI's), being allergic to penicillin and being a high risk of falls. We could not see these issues assessed or reflected in the persons care plan. This meant that staff may not have the information they need to provide the safe and responsive care.

In all of the care plans we reviewed there was a lack of personalised detail about how people wanted their care and support to be delivered. We noted that people's daily care reports were not person centred and focused on care tasks rather than people's overall wellbeing. The daily care reports were written by staff to record what care and support each person had received. However, these reports gave little insight into people's daily lives. For example, we noted for one person their report contained the same information for five consecutive days, reading, 'X assisted to wash and go to breakfast. Ate well and spent day in lounge'. There was very little variation in this information from 10 to 14 October 2017. We reviewed other people's daily care reports and found a similar lack of insight or variation.

People were not consistently being enabled to be involved in decisions made about their care and support. We asked to see copies of the residents meetings and were given a file containing feedback reports from the art therapist who attends once a week. The last resident meeting on file was recorded as 24th November 2014. We asked for other examples where the service was seeking feedback from people and the registered manager was unable to provide any. In relation to the mixed feedback people gave us around the food at Stanholm we asked the registered manager if people were involved in choosing the menu. The registered manager told us, "It is not evidenced: only on diet surveys. The cook goes around and asks people what they want. X said to stop ordering the sausages as the skin was too hard so we're doing sausage meat." However, the last mealtime audits in the file had been completed in May 2017 and people were not actively involved in setting the menus. In addition, people's views about the provision of activities had not been sought and acted upon. Subsequent to our inspection the registered provider told us that there were bi-annual family meetings where everyone had the opportunity to express their views, with one planned in December 2017.

The failure to provide person centred care is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The complaints procedure clearly set out the different stages, and people who are responsible for responding, at different stages of a complaint. We noted the provider's complaints policy and procedures were on display in communal areas. We also looked at the provider's complaints log. We noted there had been two complaints in 2017, both in relation to the management of people's clothing. These were resolved in a timely and satisfactory manner, in line with the provider's policy. The complaints procedure did not evidence who people should talk to if they were not happy with the complaint response, which should include the local authority and the Local Government Ombudsman.

We recommend that the complaints procedure is reviewed and updated to ensure that people and their relatives have clear guidance.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us that they felt Stanholm was well led. One person told us, "The manager is very good, she comes out and does some work: she sat on the end of my bed and said 'any queries come and see me'." Another person commented, "The manager; she's a nice woman, she comes round and she helps and all." A third person said, "The manager is pretty good. To be fair she is not here that much. She comes two or three times a week. I can talk to her as long as the door is open." One relative told us, "The manager is very helpful and very friendly and has always said if I want anything I can come to the office." Another relative said, "The manager seems very good. I don't often see her as I visited in the evening but she's always approachable and I can speak to her on the phone and we have met at functions." Despite these positive comments we found parts of care at Stanholm that were not well led.

The registered provider did not have effective systems in place to monitor the quality of care and support that people received. Audits were not effective in highlighting shortfalls in service delivery. Quality audits did not contain action plans for the management team to drive improvements in service delivery. For example, falls audits did not look at trends, prevention or having an action plan to reduce falls. In addition, a person who had fallen repeatedly was missed from some of the monthly audits. Other audits relating to areas such as care planning, activities, mealtimes, and medicines, had failed to identify the shortfalls we have highlighted in this report. The care plan audits were not recorded clearly, were not effective in identifying gaps in practice, such as a lack of personalised information and care plans containing out of date information, and had only checked whether there were any changes on a 'yes or no' tick sheet. This was typical of the audits we saw in that they measured activity but did not examine their quality or effectiveness. For example, the medicines audit had not identified an incorrect quantity of a controlled drug, or the fact that people were not being assessed correctly for self –medication. At our previous inspection we identified two breaches of regulation that were continued breaches from the inspection prior to that. The registered provider submitted an action plan to state that the breaches would be met. However, the registered provider did not have effective systems in operation to ensure the improvements had been made.

We found that the leadership at Stanholm was not consistently effective. There have been three previous CQC inspections dating back to September 2013 where serious concerns and breaches of regulation were identified. Since September 2013 there have been a number of breaches of regulation, two of which have been ongoing since June 2015 and remained at this inspection. The registered manager had told us following the previous two inspections that an action plan had been put in place to address the two continuing breaches of regulation. We found some improvements had been made at our inspection in June 2016 including that nine breaches had been fully met. However, this has not been sustained and we found areas where the quality of care had deteriorated since that time. The registered manager and the registered provider had been in post for all of this time and had a legal duty as part of their registration with CQC to ensure the service was complaint with Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service and making improvements. This is a breach of Regulation 17 of the HSCA Regulations 2014.

We found that the registered provider was not displaying its CQC ratings. This is a legal requirement because the public has a right to know how care services are performing. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. We checked the registered provider's website for Stanholm and found no reference to the ratings. During our inspection we looked for ratings being displayed in the service but could see none. We asked the registered manager about the display of ratings and where the ratings were displayed. The registered manager told us, "I don't think they are displayed actually: I will chase the owner to do that."

The failure to display CQC ratings in the premises and on the services' website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was a visible presence in the service. Staff told us that they found the registered manager open and approachable. One staff member told us, "I like that the manager comes and interacts with us all and doesn't just sit in the office. Whenever I've brought problems to her she gets them sorted." Another staff member commented, "She [manager] is great: you can always talk openly to her." The registered manager told us, "I think good leadership is giving staff members empowerment. Over the last few days, with very stressful and difficult circumstances you've seen the staff team step in and take control and do what needs to be done." The registered manager supervised two team leaders directly and delegated responsibility for directly supervising the staff team to the team leaders. The registered manager told us, "If there are any problems or concerns they come straight to me." The registered manager described a recent situation where a team leader had approached her about a staff member who did not seem themselves. The registered manager spoke to the staff and discovered they were having issues at home and required some time away from work. The registered manager arranged for short notice annual leave to be agreed and covered the person's shifts. This allowed the person to return to work from their leave more settled. The registered manager had utilised the providers disciplinary and performance management process to ensure standards expected from care staff were upheld. We reviewed one recent case where the procedure was followed correctly.

The culture at the service was friendly and a homely atmosphere was fostered where people felt at home. One person told us, "I feel like this is my home now." One relative told us, "The staff are always very friendly and attentive and they seem to have a good rapport with the residents." Another relative commented, "I think it is calm and there's a nice atmosphere and when things go wrong they take it all in their stride; it suits mum and she's been very happy there." A third relative said, "Everyone always seems to be fine and laughing and staff go to peoples' rooms: it seems like a very happy place and it's clean and comfortable." We spoke to the registered manager about the culture of the service and were told, "I see this as the resident's home. The staff spend a lot of time here and with the recent stresses you've seen the culture of the home is we're all one family and all help each other out."

Since our previous inspection in August 2016 there had been some positive changes enacted by the registered provider and registered manager. There had been significant improvements to the interior of the service and there had been a programme of decoration and the communal lounge had been relocated to the site of the old dining room. Staff turnover had been very low and staff sickness was being well managed. The registered provider informed us that they had improved the security around resident's personal files and these were now being kept in a locked room. We observed during the course of our inspection that staff kept this room locked.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and

oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. Relatives told us that they were informed by the registered manager whenever things changed with, or happened to, their loved ones, even if it did not reach the threshold for Duty of Candour. One relative told us, "They ring me to talk about things it was 2 weeks ago they rang to say about chest infection and they kept us in the loop."

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure that people's dignity was protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to review peoples nutrition and hydration needs in good time.