Anexas Care Limited

Stanholm Residential Care Home for the Elderly

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 23, 24 and 26 April 2018 and was unannounced.

Stanholm Residential Care Home for the Elderly is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stanholm Residential Care Home for the Elderly is located in an old detached building with the accommodation spread over two floors. Stanholm Residential Care Home for the Elderly is a dementia residential home. The ground floor has a dining room, lounge, small kitchenette, some bedrooms and the top floor is used for people's bedrooms. There is a lift that services the two floors.

At our last inspection on 19, 23 and 24 October 2017, the service was rated Inadequate and placed in special measures. We asked the provider to take action and they sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches we found. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. At this inspection we found that six of the eight breaches of regulation we previously found in relation to, medicines, safeguarding, dignity and respect, staff training and supervision, and person centred care had all been met and the service is no longer in special measures. However, despite some action being taken to address shortfalls we also found that two breaches relating to risk and quality monitoring that were continuing breaches, and we found one new breach relating to planning for people's health needs. You can see what action we told the provider to take at the back of the full version of the report.

There was a registered manager employed at the service. 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.

Quality monitoring systems required some improvements as they had not identified the shortfalls found at this inspection relating to care planning, risk assessment and implementation of activity plans. There had been some improvements since our last inspection in quality monitoring and a new system was being implemented.

People had access to healthcare professionals; however, some people were at risk of not having their needs met as care plans had not always been updated or made available to staff. Some people's assessed needs did not have care plans written for them as the programme of updating care plans was not complete.

People were being kept safe from abuse. Staff understood their responsibilities in keeping people safe from abuse and had been trained. Staff knew how to report any possible concerns. People were supported safely around risks and were encouraged to take positive risks after control measures were applied. However,

some risk assessments had not been updated on to the new format and were therefore lacking in detail. There was a plan in place to update all risk assessments. We have made a recommendation about this in our report.

Other risks such as environmental risks were being managed safely and there were protections in place in relation to possible hazards such as fire. Staffing levels met people's needs and people told us that they could find staff to help them when they needed to and we observed staff were not rushed when helping people.

People received their medicines safely and when they needed them by staff trained to administer them. Medicines were being stored and managed safely. The risk from infection was reduced by effective assessments and cleaning rotas and the housekeeping team kept the home clean. When things went wrong the provider had learned from these and had shared that learning with staff.

People's needs were met by the design of the building and suitable adaptations had been made. However, some people told us that one shower room did not have enough ventilation and was too hot. We have made a recommendation about this in our report.

People received a comprehensive assessment of their needs and support was given in line with nationally recognised tools to monitor things like people's weight and skin condition. Staff had the necessary skills and had been trained to carry out their roles. Staff had been supervised and had their performance appraised by a manager.

People received enough food and drink to maintain good health and told us that they liked the food. Staff worked in partnership to provide consistent support when people moved to or from the service. People received effective care when they moved to or from the service.

People were supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful, and the least restrictive option.

Staff treated people with kindness and compassion and people told us they liked their staff. Staff knew people's needs well and people told us they valued their staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

There was a complaints policy in place and available to people. Complaints were being recorded and acted upon. People received a pain free and dignified death at the end of their lives. Staff supported people with compassion and worked with local hospice teams. People were supported in a personalised way that reflected their individual needs. However, some people's assessed needs were not being provided in terms of their activities. We have made a recommendation about this in our report.

There was an open and inclusive culture that was implemented by the management team. People, their families and staff were engaged in the running of the service. The service was working with other professionals and local health providers to ensure partnership working resulted in good outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people, staff and others had been assessed but some risk assessments lacked detail as they were on an old format.

People felt safe and were protected from the risk of potential harm and abuse.

There was a sufficient number of staff to ensure that people's needs were consistently met.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated with learning fed back to staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had access to healthcare professionals but some people were at risk of not having their health needs met as care plans had not been updated.

People received comprehensive assessments that ensured effective support outcomes were worked towards.

Staff received effective training to meet people's needs and had the skills to carry out their roles.

People were supported to eat and drink enough to maintain good health.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

The premises were suitable to meet people's needs.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and treated them with kindness.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed, recorded and reviewed but some people's assessed activities needs were not being provided for.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to staff, people and their relatives.

People could receive a dignified and pain free death and could choose to stay at the service for the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were effective systems for assessing and monitoring quality and identifying shortfalls. However, there were areas of work that had been identified as outstanding but had not been completed.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

Staff understood their responsibilities felt able to approach the registered manager.

The views of people and others were actively sought and acted on and the service continuously learned and improved. The service worked effectively in partnership with other agencies.	

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 23, 24 and 26 April 2018 and was unannounced. Four inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. 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. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We contacted the local safeguarding and commissioning teams for feedback before the inspection.

We spoke with the registered manager, the deputy manager, one senior carer, six members of care staff and the cook. We looked at nine people's support plans and the associated risk assessments and guidance. We looked at a range of other records including five staff recruitment files, staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

During our inspection we spent time with the people using the service. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the registered manager to send additional information after the inspection visit. The information we requested was sent to us in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 19, 23 and 24 October 2017 the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. 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, and the auditing of falls had not been effective. At this inspection we found that some improvements had been made but this breach had not been fully met. We found that some paperwork had not yet been updated on the first day of our inspection, although this was put right by the registered manager.

People had falls risk assessments and falls and mobility care plans in place. People who experienced a fall had a post falls incident report and observations charts completed. One person had fallen several times in the past few months and their risk assessment had been updated to reflect the marginally increased risk rating. Certain measures to reduce the risk of falls had been implemented following the previous falls, such as a sensor mat placed by their bed to alert staff if the person got out of bed, and bed rails had been used to reduce the risk of the person falling from their bed. There had been a post falls incident report form and observation log completed following the most recent fall. This had documented action taken by staff, which was appropriate and kept the person safe. We checked the person's care plan and it was not clear that the care plan had been updated following the most recent fall. We spoke to the deputy manager who informed us that they had not updated the care plan as the person's needs had not changed and they were still being supported with a pressure mat and bed rails. However, the deputy manager agreed that the care plan would be clearer if there had been a review that recorded 'no changes'. The care plan contained information about how to keep the person safe such as having two staff support transfers, which hoists and slings to use, and what the person could manage to do for themselves. There was an audit to check if the care plan had been updated but the fall had occurred since the previous audit.

People's risks around falls had been tracked through care plans. For example, one person's admission assessment identified that they were a risk of falls and that staff should be aware of their whereabouts especially in the afternoon when the person tended to walk without purpose. The assessment identified that the person walked with a frame. These details had been carried through to the falls action plan that had recorded a recent fall that required a hospital admission. Actions had been implemented to reduce the risk of further falls, including contacting the GP to request a medicines review and request further advice; placing a pressure sensor mat next to the person's bed and checking the person through the night with the persons consent.

Falls were being audited accurately. The registered manager was using a temporary form to track falls, as a new audit tool had been ordered by the provider. The temporary audit tool was used to evaluate and analyse a range of areas including falls. The falls audit listed people's names; which staff were involved; the date of the fall; the time; the location; any injuries; the type of fall; whether there was a known cause; whether medicines were a factor, and whether the care plan had been audited. We spoke to a GP who regularly attended the service in a professional capacity, and asked about how the service managed falls. The GP told us, "I would look for certain injuries in patients as an indicator that there was an issue with falls,

and I've never seen any such injuries here, so falls must be managed well."

We reviewed a range of risk assessments with support plans covering areas such as falls prevention, personal care, maintenance of personal dignity and the person's ability contribute to their care plans. Some were detailed but others were one page documents containing basic information. We discussed this with the registered manager and were shown that a programme of re-writing care plans and risk assessments was underway. The registered manager was being aided by the newly appointed deputy manager in completing the programme re-writing care plans. The newer risk assessments were a significant improvement on the old forms and were detailed and contained control measures to keep people safe. The registered manager told us, "We are working according to risk, so are re-writing the plans for people at the highest risk first."

The failure to keep people safe from harm, as some paperwork was not in place, is a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had positive behaviour support plans (PBSP's) in place to help staff understand, prevent and manage any behaviours that others may find challenging. We reviewed the PBSP for one person and it contained good descriptions for what staff should do to support the person safely at the trigger stage, the escalation stage, the crisis stage and how to debrief after an incident. The plan also gave reasons for the person's behaviour. The person had been seen by a specialist team and ABC charts had been put in place. An ABC chart is an observational tool that allows staff to record information about the antecedent (or trigger), behaviour and consequence of a particular behaviour. Risk assessments had been completed to reduce hazards around environmental issues such as Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening regularly and staff had been trained in fire safety. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire. A PEEP gives details of the support each person would need to leave the service in the event of an emergency such as a fire. One person told us, "We have fire drills. I feel quite 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 the next inspection on 19, 23 and 24 October 2017 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. At this inspection we found that the provider had ensured the proper and safe use of medicines and the breach had been met.

There were safe medicines administration systems in place and people received their medicines when required. Medicines were being stored safely and medicines that required refrigeration were kept in a dedicated fridge. Medicines were stored in a lockable trolley with different storage areas for different people's medicines to reduce the risk of errors. The temperature of the medicines trolley and medicines fridge were taken daily and checked to see if the temperature was safe. People with topical creams were receiving these as prescribed and the application of each cream had been recorded on body maps. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted daily and counter checked. MAR charts had been signed to indicate that people had been given their medicines. Controlled drugs (CD's) were stored correctly and had been audited correctly. Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs legislation (and subsequent amendments). We checked the stock of CD's and they were correct. Where CD's needed to be returned to the pharmacy this had been done correctly and recorded in the services' CD book. The registered manager had ensured that people's GP's were regularly reviewing their medicines. Reviews of

medicines were happening on an 'as and when' basis when GP's visited people for routine appointments, or on an annual basis.

Staff who were administering medicines had received effective training and were being competency checked by the registered manager. Some people managed their own medicines and where this happened they had been regularly assessed by a senior member of staff to ensure they remained competent to do so. During medicines rounds, staff wore a tabard to ensure that people and other staff knew they were administering medicines and should not be disturbed from this task. We observed good practice in medicines administration: staff wore gloves and dispensed tablets in to clean pots; checked people took their medicines and signed MAR charts afterwards. The medicines round was not rushed and staff had the time to speak to each person and ask how they were and whether they wanted any pain relief medicines. Some people had 'as required' (PRN) medicines prescribed that were to be administered when they needed them, such as for occasional hay fever. People who had PRN medicines had a PRN protocol in place to direct staff to what the medicines was prescribed for, how much could be given in one dose and in one day, and other useful information such as adverse reactions to be aware of.

At our previous inspection we made a recommendation that the registered manager ensured that updated policies and procedures for reporting safeguarding incidents to the local safeguarding adults team were available to staff. At this inspection we found this was now in place. The registered provider had a safeguarding policy in place that included newer definitions of abuse such as discrimination and modern slavery. It contained up to date information on how to report suspected abuse to the local authority. There was also a safeguarding children policy for protecting children who may visit the service. The registered manager had a copy of the local authority safeguarding adults policy and procedure, including flowcharts on how to report suspected abuse and what responses to expect from the safeguarding team.

People were protected from abuse by staff who had been trained in safeguarding adults and understood their role in keeping people safe. Safeguarding alerts had been made appropriately to the local authority. There had been two safeguarding referrals made in the year before our inspection and these had been made appropriately. One person told us, "The best thing about living here is the security: I am safe." Another person commented, "It's safe here I would not change it for anywhere else, they go above and beyond to make us feel safe and happy. The front door is always locked, staff answer it and I don't have to like I did when I lived at home; I feel safer here." Staff we spoke with were able to identify the potential signs of abuse such as bruising, weight loss, dehydration and theft and they were clear that they would report concerns to their shift leader or the registered manager.

At our previous inspection we made a recommendation that the registered manager implement a rota system to capture the hours worked by all employees of the service and to demonstrate a systematic approach to how they reviewed staffing numbers. At this inspection the registered provider had sourced a dependency tool to review staffing hours. Once this tool was completed for each person there was a needs analysis and risk assessment for staffing levels. These had been completed for each person and a full analysis had been carried out with the provider so that the rota reflected people's needs. Staffing levels for care staff had remained the same as at our last inspection, with one team leader and three care staff on each morning shift and a team leader and two care staff on an afternoon shift. However, an extra housekeeping staff had been recruited so that care staff no longer had to do laundry duties and an industrial dishwasher had been purchased to be operated by housekeeping staff to free up care staff. During our inspection some staff told us that they felt the staffing levels at night time were 'stretched'. For example, one staff member commented, "We could do with more staff. At night it would be helpful if we had another person on. Through the night we are ok, we need help getting drinks and putting people to bed. I feel under pressure, like we haven't got enough time but we're a good team, we pull together and work hard." We

raised this with the registered manager who told us that staff had not mentioned needing more staff at night before. However, the registered manager and the deputy manager said they would each work a waking night shift to get a true reflection of what level of care was required and make any amendments as necessary.

Safe recruitment processes had been followed and recruitment systems were robust. We checked the recruitment files for five members of staff. In each case thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

People were being kept safe against the risk of infections by the prevention and control of infection hazards. Staff were completing monthly audits on the environment to ensure it was clean and without hazard, and we observed it to be so during our inspection. There was sufficient personal protective equipment (PPE) and we observed staff using this appropriately. There were disposable gloves, aprons and hand sanitiser available for staff. There was toilet paper, paper hand towels and yellow hazard bins available in toilets and bathrooms. Staff told us that toilets were cleaned every hour and there was a daily cleaning chart on display. Staff told us, "We disinfect equipment and if we ask the cleaners to give a deeper clean they respond quickly." Staff had received training in the prevention and control of infection. The cook was using the Food Standards Agency 'Safer Food Better Business' scheme to ensure compliance with food safety regulations.

When things in the service went wrong the registered manager ensured that lessons were learned and shared with the staff team. Any accidents or incidents had been recorded, investigated and tracked by the registered manager. We reviewed one example where new daily care notes had been introduced and these had led to confusion and some information not being recorded. The registered manager had identified a communication issue and that staff had not been clearly directed as to what information to include. The registered manager held a meeting with staff and agreed what information should be included in care notes. The registered manager told us, "I rolled out the new form based on what staff had told me. The lesson learned was that having good communication with staff and having an interactive approach was a better way forward."

Requires Improvement

Is the service effective?

Our findings

People had access to a range of healthcare professionals, such as GP's, opticians, chiropodists and dentist and were referred promptly when their needs changed. However, some people were at risk of not having their needs met as care plans had not always been updated or made available to staff. People's assessed care needs had not been accurately recorded. For example, we noted one person with leg wounds did not have a care plan in place for wound management. We raised this with the deputy manager and were told that the district nurses managed the person's wounds and that staff were washing the wound daily with a prescribed wash. The person had been encouraged to elevate their leg but was not keen to. The deputy manager confirmed that there was no wound care plan in place and that they had no access to the district nurse's wound care plan as their system was digital and not compatible with Stanholm's systems. We spoke to the district nurse about the person and their wounds and were told, "The communication from the home is really good. If they have any concerns, they will call across. We are based in the local hospital so we are close by. We visit the home every week." The district nurse confirmed that the staff were providing the wound care that was recommended. By the end of the first day the deputy manager had written a wound care plan for the person and had it reviewed by the district nurse.

Another person had a urinary catheter fitted. A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag. The person did not have a catheter care plan in place due to the updating of new care plans. Another person with skin care issues did not have a skin care plan in place. The person's skin was well looked after by staff and they were on pressure relieving surfaces, such as mattresses and cushions. However, incomplete or inaccurate health records meant that staff may not know what treatment people had received or required in the future which could put people at risk.

The failure to maintain an accurate and contemporaneous record for each person in regard to their health needs is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At a previous inspection 29 May and 1 June 2015 we found a breach of Regulation 11 of the Health and Social Care Act (Regulated activities) Regulations 2014 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 but the registered provider had not ensured that the requirements of the MCA were put in to practice when obtaining consent. At the next inspection on 19, 24, and 26 October 2017 there was a continuing breach of Regulation 11. We found the registered provider had not ensured that the requirements of the MCA were put in to practice when obtaining consent. At this inspection we found that this breach had been met. The principles of the MCA had been adhered to and people's capacity had been assessed and any restrictions had been applied lawfully.

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. There

were MCA assessments in place for a wide range of issues such as the completion of dignity and respect assessments, and nutrition care plans. MCA assessments showed the steps the service had taken to weigh up each person's ability to make specific decisions in line with the principles of the law. Where people had been found to lack capacity for a decision a best interest meeting had taken place and recorded a decision. People who had a DNAR in place had been assessed correctly and best interest decisions had involved families where possible. DNAR stands for Do Not Attempt Resuscitation: a DNAR form is a document issued and signed by a doctor, which instructs medical teams not to attempt cardiopulmonary resuscitation (resuscitation after a heart attack). We found where people were being kept safe with raised bed rails, their ability to consent had been assessed and the restrictions had been made lawfully.

People can only be deprived of their liberty so that they can 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 had been assessed using a 'DoLS screening tool' to determine if they required an application to deprive them of their liberty. Where this was found to be the case care plan's contained details of the DoLs application. For example, one person's application was for 'complete supervision and guidance on the grounds of dementia, confusion and disorientation' and showed evidence of review. The registered manager was keeping track of when applications had been applied for and when the authorisation expired. Where DoLS authorisations had been made the conditions within them were being met.

At our previous inspection the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Healthcare needs were not consistently responded to in a timely manner and we found a serious and significant failing for one person where their health needs were not being met as they went too long without food. At this inspection we found that people's health needs were being met and the breach had been met.

People received enough food and drink to meet their needs and maintain good health. Some people at Stanholm were at risk of malnutrition and dehydration due to their health needs. Malnutrition is a serious condition that occurs when a person's diet doesn't contain the right amount of nutrients. Where people had lost weight or had been observed by staff as not eating their meals regularly they had been referred to their GP or to a dietician for specialist support. We reviewed the care plan for one person who had been recorded as losing almost 4% of their body weight in January 2018 and had been referred to a dietician. The dietician had advised continuing the use of dietary supplements, the monitoring of food intake and weight charts. There was an action plan to use a high calorie drink and offer higher calorie foods. We checked and the actions and advice from the dietician had been followed through in practice. Food balance charts had been checked, and where the person had refused food, other food was being recorded as offered, such as snacks and biscuits. High calorie drinks, as advised by the dietician, had been recorded as regularly given to the person. Following the dietician's visit a dietetic assistant had also visited the person to review their progress and advise the service on how to keep the person well nourished. We spoke with the community dietician about how people who were at risk of malnutrition were being supported at Stanholm and were told, "They [staff] are implementing action plans and responding well. I have discharged other people [from dietetic services] as the service have followed recommendations and people put the weight on and maintained it."

People were complimentary about the quality and quantity of the food at Stanholm. One person told us, "The food is very good, I am never hungry. We have a hot chocolate before bed, I really like that. Sometimes one of the residents makes it." Another person commented, "The food is nice here." One relative told us, "I quite often visit during meal times and the food is lovely." Lunch was served in the dining room and the lounge area and some people chose to take their meals in their rooms. We observed people being offered

choices from a range of two main courses and five desserts. Food was plated up in the kitchen and served hot. Lunch time was a pleasant and unrushed experience with people talking together and the food looked and smelled appetising. People were helped to sit down, and food was cut up for people if appropriate. Menus were displayed on the tables. Specific individual diets were accommodated, for example, one person had a vegetarian meal. Care plans mentioned specific dietary requirements for religious purposes or due to allergies and we confirmed that both were catered for. One person asked staff if they could have fruit instead of the desert menu options and was told, "Yes of course you can." Staff produced the person's choice of fruit without undue delay.

At our previous inspection we made a recommendation that the registered manager implement an audit of people's preferences for meal times and record any changes in people's care plans. At this inspection we found this had happened. The registered manager had asked people to complete an 'eating questionnaire' to determine preferences around meals asking things including, favourite food; preferred place to eat; how tables should be dressed; what 'good service' meant to people, whether the person ate slowly or not, and whether music was preferred or not. The information had been passed to the kitchen and the cook was aware of people's preferences and could adjust meals accordingly.

At our previous inspection we made a recommendation that the registered manager review staff training and planning of supervisions and appraisals to ensure they were provided in line with staff need and best practice. At this inspection we found this had happened.

Regular supervisions and appraisals were in place. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice. The registered manager had completed a supervision planner for the year to track when staff would have supervision and appraisal. Staff confirmed that they were effectively supervised. One staff member told us, "We have supervisions all the time and appraisals with the manager every six months to a year." The deputy manager confirmed that they had received regular observation and feedback from the manager who had, "pointed out little things positively".

People's needs were assessed and their care was planned to ensure their needs were met. There were assessments of people's needs prior to a service being provided. Pre-admission assessments examined people's needs in terms of their sexuality to determine if there were any support needs around people's protected characteristics. Protected characteristics are the nine groups protected under the Equality Act 2010. People's disabilities were assessed in terms of the support that people needed around areas such as dementia or anxiety. There was appropriate use of nationally recognised assessment and management tools for malnutrition and wound care.

Staff had the skills, knowledge and experience to deliver effective care and support. The registered manager had recently changed training provider. The registered manager told us, "I contacted Skills for Care and had a company recommended and we trialled one course which was good so have booked the remaining courses." Staff had received training in a range of courses relevant to their roles, such as medicines, fire safety, dignity and respect, and safeguarding. Where a need had arisen staff had been given supplementary training, for example palliative care training. New staff were receiving an effective induction prior to working with people. The induction was managed via a portfolio created between the registered manager, the provider and their consultant to create a package that was unique to the needs of the service.

Staff worked together to ensure that people received consistent and person-centred support when they moved from or were referred to the service. The registered manager assessed people's needs prior to them moving into the service. The deputy manager told us not everyone who was assessed was accepted. The

registered manager reviewed notes from social services, met the person, and then completed an assessment. The assessment included checking people's medical histories, medicines, activities of living and included a cognitive assessment. The person and their relatives were then invited to visit the home to ensure the registered manager and the person were satisfied it could meet their needs. People had a 'transfer of person to hospital' form in place, which was used to provide consistent care and treatment should the person need to attend hospital.

People's needs were being met by adaptations made to the building and the environment. There was a stair lift, and shaft lift, to support people to access the first floor. There was clear signage on doors to indicate to people who may forget the use of each room, such as the bathroom. One staff member had painted a mural in the living room, which people told us they liked. People were supported to access the garden. People told us they sat in the garden when the weather was nice, and were supported by staff to exercise in the garden. Bedrooms were individual and contained personal items and furniture. We noted some areas of the service were in need of updating, for example on the first floor where painting of the hallway had commenced but not finished. One person told us of the home, "It's a little tired." The shower room on the ground floor did not have a fan or window for ventilation. As a result staff told us it could get hot and uncomfortable for staff and people using the shower. An internal door near the main entrance near the office opened inwards to the service, creating a potential hazard, as the door could hit someone when opened. We raised these issues with the registered manager who told us that they would pass these concerns to the maintenance worker. By the end of our inspection the internal door had been removed.

We recommend that the registered provider reviews ventilation in the shower room to ensure it is comfortable for people and staff to use.

Good

Is the service caring?

Our findings

At our previous inspection on 19, 23 and 24 October 2017 there was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that people's dignity was not consistently upheld. At this inspection we found that staff supported people in a way that upheld their dignity and the breach had been met.

People's privacy, dignity and independence was respected and promoted by staff. Personal care was delivered in private in people's bedrooms and communal toilets with the doors being closed. The registered provider had ensured that all staff had received dignity and respect training. Each person had a 'dignity and respect information' sheet. These contained detailed pictures of each person and how they would like to be treated. For example, one person didn't like eating in front of others and preferred their meals on a tray in their favourite chair; another person preferred to be called a different name to their given name, and a third person, who was living with dementia, was described as displaying youthful behaviour and staff were instructed how to uphold this belief for the person. By capturing and reinforcing people's images of themselves, staff were upholding people's dignity and personhood.

Staff knew people well and relied on their day to day interactions and observed behaviour patterns to support people's communication and ensure that they were being shown dignity and respect. Staff were very proud of their close relationships with people and described them as 'trusted relationships'. For example, one staff noticed one person did not have make-up on, and commented that they usually liked to. Staff then supported the person to apply their make-up so they could still present themselves to others in the way they preferred to. Staff told us, "I think its lovely she likes to do her make up."

Files that contained confidential information were seen to be kept locked away and computers were password protected. Peoples' privacy was respected. One person told us, "They always knock on my door which I really like and often tell them they don't have to do that." People told us that they were supported to maintain independence. One person said, "Staff help as much as they can to keep my independence. I am aiming to go home with care in place, so I will keep my independence." Where people could sign their own care plans they had done so and other people had care plans signed by relatives. People funded by the local authority had been involved in the review of their care plans. People who were not keen to eat were encouraged by staff to try food for themselves before being actively supported to eat. Where people didn't eat they were offered drinks and supported to make a choice. One staff told us about how a person had taken back control of part of their care routine. The staff said, "We used to assist her with creaming her legs, but she has started to do it herself. She also used to ask us to put her socks on, but now she has the confidence to do it herself."

People were treated with kindness and compassion in their day to day care. People and their relatives told us that staff were caring. One person told us, "The staff really are kind. They treat me with kindness." Another person commented, "I have to get up when my blood pressure tablet has to be taken and staff always bring me toast with marmite and tea which is lovely." One third person said, "[Staff] bought me in a set of books to read, and sometimes brings me a DVD; she's very good." We observed staff interacting in a warm and

supportive manner towards people. During a seated exercise session staff made every effort to include everybody in the room. They asked each person a question to make the exercises into a game and keep the rapport going throughout the session. We saw a member of staff taking great effort to position a tray so that a person could reach their drink. "Tell me when to stop" the staff member said as they slid the tray into position. Before lunch, staff supported people to the table. One person did not want to go into the dining room and staff supported them with this choice. The staff member maintained good eye contact as they asked permission to use a clothes protector. Once the person had agreed, the staff gently helped to place a clothes protector on the person.

Staff were observed throughout our inspection to be supporting people with good humour, warmth and genuine affection. We observed staff speaking to people in a friendly but respectful manner. Staff commented on people's appearance positively. One staff told a person, "I love your colourful hat, it's so lovely." When the person joked back that they tried to look nice but rarely looked good at their age, the staff member, laughed back, hugged the person and told them that they always looked lovely. Another person commented that they loved the sunshine. One staff heard this and asked, "Well why don't we go and walk round the garden?" The person said they would love to do that so the staff took them by the arm and went for a walk.

Staff used humour appropriately with people to create a homely and warm atmosphere. One person mobilised with a walking frame more quickly than their friend. A staff member commented to the person walking more slowly, but loudly enough for both people to hear, "Oh look here comes speedy Gonzales." The quicker person commented, "I'll show you; I'll chase you round the garden." Both people and the staff laughed at this and then sat together and had a long and pleasant conversation about the garden and possible plans for planting.

People were supported to express their views and be involved in decisions around their care. We looked at how the service supported people with their individual preference and life choices. Staff told us, "We talk to people and have conversations; it's all about what they think not what I think." People's care plans had been implemented around mental capacity assessments and if people had the capacity to be involved in the planning they were given care plans to complete, or staff sat with them to write plans. People were able to choose their food for the day and had access to regular residents meetings.

Requires Improvement

Is the service responsive?

Our findings

At a previous inspection on 29 May and 1 June 2015 we found a breach of Regulation 9 of the Health and Social Care Act (Regulated activities) Regulations 2014. 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. At the next inspection on 19, 23 and 24 October 2017 we found that the required improvements had not been made and the registered provider continued to breach this regulation. At this inspection we found that action had been taken to meet the breach but we have made a recommendation to ensure that people's assessed activities needs are provided.

There was a programme of activities in place and these had been reviewed. One person, who had routinely refused to engage with activities in the past, had completed a social activities assessment with their key worker. This had identified the person's preference for their own company as well as giving staff some ideas of other activities they could try with the person. Other people's assessments had identified that they had wanted to be involved with organising activities. We saw a new activities planner that had a list of activities with a staff member allocated as responsible for co-ordinating. There was a range of different activities such as making biscuits, exercise to music, nail care and bingo. However these activities had not always happened as planned. The registered provider had been actively recruiting an activities co-ordinator but had been unsuccessful in appointing to the role. We saw recruitment paperwork including adverts for the role that had been unsuccessful. The registered manager had identified that more work needed to be done to implement the activities and had a plan to write activities care plans, introduce new activities including bowls and darts that people had requested, and to have a full plan of communal activities and scheduled individual activities in place by the end of May 2018.

We recommend that the registered provider implements the planned programme of activities to provide meaningful occupation to people.

We did, however, witness a number of activities. We observed staff playing a hoop game with people in the lounge. People were actively encouraged to play by staff who were enthusiastic. During the game people were observed to be smiling, laughing, cheering and clapping along. One person was out having their hair done. Another person was supported by staff to paint their nails, and showed them to us with pride once finished telling us "You know red is my favourite colour." When the staff asked if anyone else wanted their nails painted the person recommended the staff member. One gentleman joked he wanted his nails painted, but then went on to have his nails trimmed by the carer. One person was noted as feeling 'down' by staff, and therefore taken out for tea, cake and fresh air into the local village. The staff told us, "We went out for a walk, it was nice to see the flowers, and we usually don't get time to take it in when we drive in the car." Six people attended an age UK day centre every week. People were supported to maintain their spiritual beliefs. Two people attend church on a weekly basis, whilst others practiced their faith when the local church held a fortnightly service at Stanholm. People were supported to attend coffee mornings at the

church. People told us they enjoyed visiting the local market. Some people watched TV, whilst others read the paper or read a book. People did arts and crafts and their artwork was displayed within the home.

At the last inspection, some people were found to be at risk of social isolation. At this inspection, staff told us they routinely checked on people who preferred to be in their rooms. People told us they were given the choice how they spent their time, those who were in their bedrooms choose to be in there, and were happy staff respected their decision. Staff and people told us they checked on people regularly, offering drinks and chatting to them; however this was not being formally recorded.

At our previous inspection the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. People's needs had not been consistently reviewed, care plans lacked personalised information and people were not consistently being enabled to be involved in decisions made about their care and support. At this inspection we found that people's care was planned in a person centred way and the breach was met.

Care plans had personalised information and contained details about people's histories. We saw that some people had 'family trees' in place to explain who different members of their family were and how they were related. People living with dementia had completed The Alzheimer's Society's 'This Is Me' booklet that gave good background information on the person's life. For example, if they had been married, if they had children or grandchildren, and a level of detail that would be useful for staff to know, such as one person who lost their father in the war and was bought up by their mother. Other people had detailed histories around when they had left school, jobs they had worked or places they had lived in. There was information about how people wanted to be supported in the present such as whether people preferred to shower or bathe and when and how they liked to do this. Some people living with dementia could become distressed when they were disoriented to place or time. Where this was the case people's behaviour was explained clearly, such as asking for a certain name, or wanting to see their parents, and a clear description was given on how to support the person.

People were being supported in a person centre way. One person liked to read a particular paper every day and this was left out for them in their favourite chair every morning by staff. This person told us, "I have always read the [name of paper]; it's my paper." Another person was observed throughout our inspection to have a teddy bear and a doll with them at all times. These brought the person comfort and staff treated these objects as preciously as the person did in order to maintain their personhood and uphold their dignity.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The registered provider had a complaints policy in place that set out the process for people to complain and what they could expect in terms of a response from the provider. The policy identified that people unsatisfied with the response to their complaint could contact the local government ombudsman, and gave the contact details to do so. Complaints and their responses had been logged so the registered manager could track them to their conclusion. We reviewed one complaint that a person had made about their room being too cold during winter. An additional heater was sourced and a thicker pair of curtains was provided following a check of the room. The complainant had recorded that they were very satisfied with the response.

People were supported to have a pain free and dignified death when they were at the end of their life. People had advanced care plans in place to set out their wishes for end of life care. Where people wanted, there was family involvement in this plan. People's preferences and choices for their end of life care were kept under review and acted upon. People could state whether they wish to be resuscitated or not and this

information tallied with people's DNAR forms. DNAR stands for Do Not Attempt Resuscitation: a DNAR form is a document issued and signed by a doctor, which instructs medical teams not to attempt cardiopulmonary resuscitation (resuscitation after a heart attack). Cultural needs had been discussed and people had been asked if they wished to have a religious minister present, or someone else present in their final moments. Where people had preferred funeral directors this was recorded and family had made specific instructions, such as to ensure that wedding rings or other important personal items were removed and stored safely following death. We spoke with a GP about the services' ability to care for people at the end of their life and the GP told us, "The end of life care is very good here and they try not to send people to hospital; they liaise well with the hospice."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on19, 23 and 24 October 2017 there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that the registered provider did not have effective systems in place to monitor the quality of care and support that people received and the leadership at Stanholm was not consistently effective. At this inspection we found that although there had been significant improvements made to the leadership of the service and to audits, there were still some areas that needed improvement, therefore the breach had not been fully met.

There had been a new audit system implemented that was a significant improvement on the previous audit system. The registered manager had been auditing the service with regular checks of areas such as medicines. The registered provider had employed a specialist consultant and had been completing joint audits with the consultant. These had generated action plans with areas highlighted for improvement, such as care plans requiring further work, and the need for a deputy manager to be appointed to assist the registered manager in completing the work schedule. However, despite the audits identifying the need for paperwork to be updated and completed, and a deputy manager being appointed from within the staff team, there were areas of work that had not been completed by the time we inspected the service. For example, some care plans were still in progress meaning that people's healthcare needs had not consistently been identified in care plans; some risks assessments were not detailed enough as they had not been recorded on updated forms (as the old forms were not sufficient to record all the necessary information) and people's assessed activities had not been consistently provided.

The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service and making improvements. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our previous inspection the provider was in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not displaying its CQC ratings. At this inspection we found that ratings had been displayed on the website and within the service and the breach had been met.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be informed of our judgements. The provider had displayed the rating conspicuously in the service and there was a link on the provider's website to the latest CQC report. 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 service 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 aims to ensure that providers are open, honest and transparent with people and others in relation to care and support and when untoward events occur. The registered manager was given good support from the registered provider and their specialist consultant who supervised and appraised their performance and oversaw quality monitoring with the registered manager.

The culture within the service had undergone a change and the service was open and inclusive. The registered manager was a visible presence in the service. One person told us, "The manager is good. I felt a bit fed up and she took me out in her car to the garden centre for a cup of tea and it was lovely." The registered manager had kept the day to day culture of the service under review and had an open door policy. Staff came to the office and spoke to the registered manager about any day to day issues that occurred. The registered manager told us, "I am visible and do walk-arounds, serve lunch, help at breakfast; it's a small home and being visible helps to keep issues under control." The registered manager explained how the culture in the service was under constant review from management and staff. The registered manager challenged staff about leaving their coats and bags lying around as it was someone else's home. The registered manager told us that they had also been challenged by staff when they were handing biscuits round to people. The registered manager said, "Staff reminded that I would have told them to use a plate and serviettes, and staff quite rightly can challenge me back to get the right culture."

The registered manager had supported staff and ensured they felt valued and listened to. Following our previous inspection, where the service was rated as Inadequate and placed in to special measures, the registered manager had requested that staff work as a team to make the improvements necessary. One staff told us, "Managers ask for feedback. We speak with team leaders, and raise any issues with them. Expectations are definitely clear in terms of roles and responsibilities; I am very confident to raise concerns." The registered manager was aware of challenges and the risks to the service including being a small service and the difficulty in recruiting suitable staff. The issues around recruitment were being addressed by using one agency and ensuring the same staff were requested when used.

Staff received feedback from managers in a constructive way. Staff had positive supervisions with tasks set and daily meetings with senior staff through the open door policy. The registered manager told us. "Staff come and talk about things, most of the time it is a personal issue but as a manager I listen as I value the staff." The registered manager felt supported by the registered provider (who is the owner of the business) and they were available at all times to the registered manager. The provider did an initial round of supervisions following the previous inspection to meet all staff and give staff access to the owner. The registered manager said, "I always get a response for information and the owner is always open to discuss budgets and staffing." The registered manager had ensured there were robust arrangements in place to ensure the security and integrity of confidential data. The registered manager was aware of the General Data Protection Regulation that has recently come in to force and training for staff was being sourced from a specialist consultant.

People, their families and staff members were involved in the service and regular feedback was obtained. Staff were actively involved in developing the service and had been encouraged to propose new ways of working. The registered manager and the provider had wanted staff to do more for people and staff had explained that the amount of cleaning and housework was making this difficult, so an extra housekeeping staff was employed. Staff also had input around the timing of the rota and had requested the extension of one shift to allow more evening tasks to be completed and this had been enacted. The service had links with the local community beyond key healthcare services. Some people attended an 'Age UK' day centre, and Holy Communion was delivered fortnightly in the service by a priest from a local church. Some people attended a local church twice a week and the service received invites for events at the church that people could choose to attend. There is a local voluntary café in Edenbridge that some people attended and there is also an over 65's walking group some people had been attending prior to poor health. There were regular staff, residents and relatives meetings to enable people to have their say in the service. The service had also sent questionnaires to people and relatives to gather their feedback and act on suggestions.

The service was undergoing a period of change and implementing a continuous development strategy.

Resources and support had been made available to the registered manager and the staff team to develop strategies for improvement. The registered manager told us, "The biggest resource has been the specialist consultant [sourced by the registered provider to help improve the service] who provided information, training and has given us lots of tools." The registered manager had joined with Skills For Care and had sourced a new training company and attended a registered manager's network with their support. Skills for Care is an independent registered charity working to set the standards and qualifications to equip staff with the skills and knowledge needed to deliver high quality care to people. Information from incidents was being used to learn lessons and the learning was shared with the staff team to drive quality improvements. Incident reports were being reviewed by the registered manager and learning identified had been shared with the staff team during staff meetings.

The registered manager had a good working relationship with the local health and social services. There were strong links with healthcare professionals such as GP's, district nursing teams; occupational therapists, and dieticians. The local hospice worked in partnership with the service when people were at the end of their lives and had allocated a nurse to each person. The service was working closely with the local authority and was in regular contact with social workers and the safeguarding adults team. The local authority commissioning team visited regularly to conduct quality visits and social workers had attended annual reviews at the service. The service had been working in an open and transparent manner with the local authority following the last inspection. Information and assessments had been shared appropriately with relevant agencies for the benefit of people who use the service. The registered manager told us, "We try and share information verbally and face to face but when we email things to social services we use an encrypted system to protect peoples' data. With GP's we only exchange information face to face." The registered manager had been appropriately sharing information with other services, for example when people moved out of the service the new provider would be securely given copies of care plans and risk assessments.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to maintain an accurate and contemporaneous record for each person in regard to their health needs. The registered provider had failed to keep people safe from harm, as some paperwork was not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service and making improvements.