Anexas Care Limited

Stanholm Residential Care Home for the Elderly

Inspection report

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Date of inspection visit: 29 May and 01 June 2015
Date of publication: 02/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Stanholm Residential Care Home for the Elderly on 29 May and 01 June 2015 and the inspection was unannounced.

Stanholm Residential Care Home is located in Edenbridge and provides accommodation and personal care for up to 26 older people The home is set out over four floors and a basement. There is lift access between the ground floor and upper levels. At the time of our inspection there were 23 people living at the home. Some people received care in bed, some were living with dementia and/or had mobility difficulties and sensory impairments.

The home had a registered manager. 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.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of this report.

People said they felt safe living in the home and relatives told us that their family members received safe care. However, we found that staff did not understand or have the necessary guidance and information to appropriately report and respond to allegations of abuse in the home.

People had some individual risk assessments. However we found areas of assessment missing and some assessments that had not been updated or reviewed when people's needs changed. This meant staff did not have the information they needed to ensure people were safe.

We identified a number of maintenance issues that impacted on people's wellbeing.

We found that where staff covered for absent colleagues and carried out cleaning, cooking and laundry, this meant there were not always enough staff to ensure that people's care needs were met.

Safe recruitment procedures were not always followed. The registered manager had not always checked references, to make sure the staff employed were suitable to work with people.

Medicines were not always stored and administered safely in accordance with best practice guidance.

Staff knew people well but not all staff had received the appropriate training and appraisal to ensure they could deliver care and treatment to service users safely and effectively.

We observed that staff sought people's consent before providing care and support. However when we spoke with staff and management they did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Assessments of people's capacity to make decisions had not been carried out in line with the 2005 Act.

People told us the staff were respectful and kind. However records were not always stored securely and therefore people could not be assured that their personal information would be kept confidential.

The system for encouraging and managing people's complaints was not formalised or recorded. We have made a recommendation to improve this.

Staff were caring in their approach. However we observed that the people who required the most care and support were not always given the support they needed to ensure they had meaningful occupation during the day.

People felt the home was well run and were confident they could raise concerns if they had any. However there were not robust systems in place to assess quality and safety.

The registered provider had not adequately monitored the service to ensure it was safe and had not identified areas where improvement was required.

The registered manager had an understanding of their role and responsibility to provide quality care and support to people. However we found that they had not always met their registration requirement in notifying the Care Quality Commission of key events including when people had died.

The home environment was not always suitable for people and we have made a recommendation about improving this.

People who spent time in the lounge did not have a means of summoning staff help and staff were not always deployed to meet their needs. We have made recommendations to improve these areas of care.

The care plans did not always give the staff the information they needed and staff relied on their knowledge and verbal handovers rather than documented plans of care. We have made a recommendation to improve this aspect of the care.

People were supported to eat and drink adequate amounts and completed questionnaires showed people were satisfied with the food provided.

Staff communicated well with people.

People received medical assistance from healthcare professionals including district nurses, opticians, chiropodists and their GP.

People were treated with respect and dignity.

Summary of findings

Information about how to complain was displayed in the entrance lobby. People were supported and encouraged to maintain links with family and friends.

There was an open culture where people, their relatives and staff felt supported and were confident that they could discuss concerns.

Summary of findings

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 were not protected from the risk of abuse because staff did not know the correct procedures for raising a safeguarding alert with external agencies.

Risk assessments were not always sufficient or updated appropriately to ensure that staff had clear guidance in order to meet people's needs safely.

The registered provider had not ensured the home and gardens had been appropriately maintained.

There were not sufficient staffing levels to safeguard the health, safety and wellbeing of people.

There were not safe recruitment procedures in place to ensure that staff working with people were suitable for their roles.

The registered provider had not ensured that there was safe administration and storage of medicines.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had not received training and supervision relevant to their roles. Staff felt they received good support from their manager.

Staff and Management did not have a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and their responsibilities.

People were provided with adequate nutrition.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service was not consistently caring.

Personal information was not stored confidentially.

People told us they found the staff caring, and they liked living at Stanholm Residential Care Home.

People were treated with dignity and respect.

Staff respected people's right to independence.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

People did not have their social needs met and were not supported to take part in meaningful personalised activities and were at risk of social isolation.

People knew how to make a complaint and were given opportunities to give their views. Relatives told us they were kept well informed.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The Statement of Purpose was out of date and gave inaccurate information.

The registered manager had not notified the Care Quality Commission (CQC) of serious incidents, events and deaths when required to do so.

There were ineffective systems to assess quality and safety of the services provided.

There was an open culture. Staff felt supported and were confident that they could discuss concerns. People who used the service and their relatives felt the staff and manager were approachable.

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 29 May and 01 June 2015 and was unannounced.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the visit we looked at whether we had received any notifications. A notification is information about important events which the home is required to send us by law but we found that none had been sent.

We spoke with 13 people about their experiences of using the home. We also spoke with the registered manager, 7 care staff, the cook, three relatives, one visitor, two district nurses and a G.P. We examined records which included 7 people's individual care records, five staff files, staff rotas and staff training records. We sampled policies and procedures and the quality monitoring documents for the service. We looked around the premises and spent time observing the support provided to people within communal areas of the service. 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

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said, "I do feel safer here than I did in my own home because the staff look after me so well." Another person said, "The staff are so kind and they make sure I am safe". One other person said, "Even the night staff are so good and I never feel worried here". Although people told us they felt safe, we found that the systems to protect people from harm and abuse were inconsistent.

Staff were able to describe some signs of possible abuse and they told us they would always report this to the registered manager. However, they did not have the guidance to know how to report abuse appropriately to the local safeguarding authority. Guidance for reporting abuse to the local safeguarding authority was not easily available and although there was a policy for this, it did not include accurate contact details.

This meant people were not protected from the risk of harm or abuse because staff did not know how to respond and did not have easily available guidance follow. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014

Staff knew how to respond in the event of a fire. They described how they would all assemble at a point in the home and then take instruction from the most senior person on duty. Although staff said that fire doors would automatically close to protect people from fire, we found that not all fire doors were working effectively. For example, one person's bedroom door had a broken handle on the inside so the door could not be shut to protect them in the event of a fire. A fire risk assessment had been undertaken by an external consultant in 2013 but this had not been reviewed since. The risk assessment included a comprehensive action plan but there were a number of actions that had not been completed. This meant that people were at risk, as action identified to keep people safe had not been taken.

In the event of other emergencies, staff were aware that people could be evacuated to the nearby local hospital. A number of people were living with dementia and had mobility and sensory needs, but risk management strategies were not consistently in place. For example there were no individualised risk assessments for evacuating people in the event of an emergency. This meant people were at risk, as staff did not have the information they needed to make sure they would be able to help people safely in an emergency.

The management of risks were inconsistent. In some but not all instances, staff recognised when people were at risk and took action to avoid the risk occurring. For example staff were able to tell us which people were at risk of experiencing falls and how they used appropriate equipment and ensured that items of furniture were not in people's way. Some care plans contained information which indicated people were at risk of falling but no risk assessment had been completed. One person had been assessed as at very high risk of developing pressure sores. This person's plan of care did not contain any risk assessment and although staff told us they were checking this person's skin and had the equipment they needed, there was no formal plan to ensure this person had their needs met consistently by all staff. Where risks had been assessed there was little guidance for the staff to follow to make sure people were cared for safely. The staff relied on their knowledge of people, rather than planning for risks and written guidance about how to protect people from the risk of harm.

Not all people were protected from the risk of harm because staff had not identified all potential risks, and did not have easily available guidance to follow. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We raised the issues of individualised risk management with the registered manager and on our second day some risk assessments had been updated and others were being revised.

During our inspection we found a number of issues that required maintenance, including broken garden furniture, bedroom door handles not working, a broken toilet door lock, a shower door broken, loose carpeting, water damaged areas on the first floor, the lift out of operation and a roof leak that resulted in water coming through the second floor ceiling. The registered manager told us they employed a maintenance worker for small repairs as and when required, but there was no maintenance log or planner to record when repairs had been requested and undertaken. Staff told us, "It needs gardening, painting and things need fixing - having pride in it" and "It needs a facelift." Staff explained how the registered manager had

Is the service safe?

purchased new weighing scales with some money left to the home. Some staff felt that the home needed greater investment to ensure it had the equipment and environment suitable to meet people's needs. One member of staff said "People get a good service with what we have got." and "It's make-do."

The lack of an effective system to ensure the home was maintained to an appropriate standard was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We raised these issues with the registered manager and on our second day a maintenance log had been set up and some smalls repairs made and others scheduled.

People told us there were enough staff to care for them. One person said, "The staff are around and they come to help me". Another person said, "I never wait long, staff always come when I ask them". One health professional told us, "As far as I am concerned it's always well-staffed, there are staff around and you don't have to hunt around for them." Despite people's positive views, we found there were times when staff could not provide all the care people needed. Staffing levels were not based on an analysis of people's support needs and had remained unchanged even when people's needs had changed. One member of staff told us "Staffing levels have never changed, if people's needs change we have to step up the work." The deputy manager told us that they never used agency staff to cover staff absences because they wanted to make sure staff knew the people they were caring for. They said, "We all muck in together and work extra hours when it is needed. We also do other jobs in the home such as cleaning, as the cleaner is off this week. We also cook when needed and the night staff do the laundry". The layout of the building made it difficult for staff to supervise and support people. Bedrooms were positioned across three floors and many people stayed in their rooms. We observed there were times when people were alone in the lounge for up to an hour with no staff interactions. One person said, "The staff say they are too busy to spend time with me sometimes." Some staff had a different view saying there were enough staff and they were not rushed. One member of staff said they did visit people's rooms and spend time with them. They said, "We strike up conversation and make sure they are O.K but maybe the half and hour we spend with them is not enough when they are in their room all day long". Staff did their best to respond to people's needs but one staff member told us, "They all seem quite happy, it's a case of keep popping your head in and out.".

This failure to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the staff files did not contain all the information to assure the provider that they were safely employing suitable staff to work with people. Staff told us they had completed an application form, attended an interview and been asked for two references before they started to work in the home. One member of staff was working without any references having been sought. Of the five files we saw, only two showed that the checks, references and forms that were required for safely employing staff had been carried out. Checks carried out by the registered manager were inconsistent and therefore ineffective in making sure that all staff were employed safely and suitable to meet people's needs.

Staff told us they had induction training when they first started work and that they shadowed experienced staff. The newest member of staff had previously worked in the home as a volunteer so already had some understanding of people's needs. However we found one example of a one day induction checklist where a member of staff had been shown basic tasks and the safety procedures. Apart from this there was no recorded evidence that staff had taken part in training to understand their role.

The failure to carry out safe recruitment practices to ensure staff were suitable to work with people was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these issues with the registered manager and on our second day, we were shown that references had been sought.

People told us they were given their medicines at the correct times. One person said, "They are never late giving me my medicines and they help me". Another person said, "I get my medicine when I need it". A visiting G.P said the staff helped people to take the medicines they needed and they always informed them if they had concerns about people's medicines. Despite people and the G.P's positive

Inadequate

Is the service safe?

views, we found that medicines were not always stored or administered safely. The deputy manager and staff told us that because the lift was not working they were unable to use the medicine trolley because they were unable to get the trolley up and down steps. We saw one member of staff take the days medicines to the dining room and whilst they went to give one person their medicine, they left the packs of medicine on an open shelf. This was a potential risk to people, especially those living with dementia as they had access to medicines not intended for their use. We saw two members of staff giving people medicines and one member of staff gave these safely and as prescribed. One member of staff used their bare hands to tip the medicine into someone's hand and in another instance pass the medicine directly into a person's mouth. This is not best practice when administering medicines for the safety of the person and the staff. Both staff correctly completed the medicine administration records and these records were accurately maintained. The staff told us they were aware that there was a policy they needed to follow when obtaining, storing, administering and disposing of medicines. However, we found they were not putting the policy into practice. The registered manager told us that two team leaders were mostly responsible for giving medicines. These staff had last received training in 2010.

The registered manager said they had not checked the staff remained competent to manage medicines safely since then. The staff said no one had checked they were able to give medicines safely. We observed some examples of poor practice which showed that people were not always being given their medicines safely.

One person's medicine came under the Misuse of Drugs Act Regulations 2001 and required specific safe storage under the Misuse of Drugs (Safe Custody) Regulations 1973. Whilst this medicine was being recorded accurately using the correct procedures we observed that it was inappropriately stored alongside all other medicines in the trolley. The registered manager told us they had previously kept such medicines in a safe but had been advised it was acceptable to store it in the trolley. The registered manager looked up the guidance on keeping certain medicines in care homes and acknowledged that the instruction for safe storage was clear. Despite any previous guidance the registered manager and the provider have a responsibility to ensure that they safely follow the act and associated guidance.

The registered provider had not ensured that there was safe administration and storage of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

People told us the staff cared for them well. One person said, "The staff do what I need them to do for me". Another person said, "The staff care for me well and do everything I need".

Staff knew people well because they had worked with them for a long time. For example, staff described who liked to get up earlier or later and what personal care each person needed and how they met these needs. There were forms in people's care plans which were intended to record what care people had received each day. Staff told us they were meant to complete these records. Although staff had made some brief notes these forms were not completed so staff were unable to show whether people had received the appropriate care.

Staff said they had received the training they needed to carry out their roles and deliver effective care. The training records showed that staff had attended training but this had not always been updated regularly to ensure staff were following best practice. Staff said that when they requested additional training this had been arranged. For example, staff told us they had requested catheter care training and this had been completed. One person required catheter care and the district nurse told us staff attended to this person's catheter care effectively, keeping the catheter clean and checking regularly to ensure that no infections occurred. The visiting G.P told us the staff cared for people effectively and staff seemed to have the skills to meet peoples' needs. They said people had their oral care attended as well as other aspects of their personal care. They said, "People are well cared for they look well and it is positive how well the staff know them".

The registered manager had not carried out any competency checks to ensure that staff were using their training in practice when delivering care. Staff had had annual appraisals in 2014 and 2013. The intention of appraisals is to ensure staff review their standards of work, discuss any concerns or training needs and plan for any development in the year ahead. The records of the appraisals we saw were very brief with one line written against each heading with no plans for developing the staff's skills or experience. The registered manager told us staff did not like being appraised and they and the deputy manager had not been trained to carry out effective appraisals. Staff did say they felt supported by the registered manager and the deputy manager and they could always ask questions of seek guidance. Staff meetings had not taken place regularly and information was passed informally between staff, so although they felt supported there was no formal system for supporting staff or monitoring their practice.

Not all staff had received appropriate training and appraisal to ensure they could deliver care and treatment to service users safely and effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People said the staff asked them for their agreement before carrying out care. One person said, "The staff always ask me what I need and if it is O.K to do something". We observed staff asking people what they wanted and waiting for their responses before they cared for them. One person who had no family had a solicitor who held enduring power of attorney and the registered manager knew they would need to be consulted if anything other than day to day decisions needed to be made. One person's care plan contained a 'Do Not Attempt Cardiac Pulmonary Resuscitation' order. This had been correctly completed after consultation with the person and their family and signed by their G.P. The staff knew about this order and what it meant for the person's care. Another person had been consulted about their end of life wishes and they had signed to say they agreed with the plan. One of the care plans we saw contained a mental capacity assessment. Staff were unable to describe the principles of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards (DoLS) even though they had completed training they said they were unable to remember what this meant. After some prompting one member of staff said, "I think it is to do with giving people choices and letting them say what they want". The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely. The management did not know when a DoLS application should be made or when best interest meetings were required for decisions on behalf of people who were not able to make important decisions for themselves. For example, one person living

Is the service effective?

with dementia had a care plan that stated they lacked capacity and a risk assessment in place that noted the front door was to be locked to prevent the person leaving, however no DoLS application had been submitted.

Staff and management did not understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Assessments of people's capacity to make decisions had not always been carried out in line with the 2005 Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff knew people well enough to know how each person communicated and were able to describe how different people communicated and how they helped them to understand. For example, one person used hearing aids and we saw staff bending down close to the person to talk to them and checking the person had heard what was said. Staff understood that another person was very determined and so understood that they could offer help but may need to go back at a different time or wait for the person to ask for assistance. One person became upset several times and staff took time with them to reassure them, talking quietly and using gentle touch until they became more settled.

People told us they liked the food. They said, "The food is really very good here, and you can always have alternatives" and **"**I like the food and I've put on weight since I've been here." We observed the lunch time meal where people ate either in their bedrooms or in the dining room. People were given a choice and meals were served quickly and looked appetising. One district nurse told us "There is always a lovely spread of food and we've seen that people are offered choice." Earlier in the day we had met the cook as she walked round the home speaking with people to find out what cooked meal they preferred. The cook explained that she liked to chat with people and spend time with them and was able to describe people's individual preferences and dietary requirements. We saw records and notes in the kitchen that showed people were given a choice and that people were asked their views through questionnaires. People who ate in the dining room were mostly independent, but we observed that where people required support, food was cut up and plate guards used to help them remain as independent as possible.

During meal and snack times staff were attentive, spoke with kindness and offered people choices. At one time we heard a member of staff chatting and laughing with people. Drinks were readily available throughout the day and those that were able, were free to help themselves. One person told us, "You can do exactly what you want, if you want a cuppa at 3am, you can."

People told us that staff supported them with their health needs. One person said, **"**When I came here I was in a big plaster as I'd broken my hip, and the staff really helped me, I can now walk with my frame which is lovely." One district nurse said "Whenever we ask them to put something in place they sort it. If they have any concerns about someone they are always quick to get us to come in and check." Care plans and the staff handover book showed that people's health and wellbeing was monitored. Records also showed that people had regularly seen the district nurse, optician, chiropodist, and had attended hospital appointments when needed. People were supported with their physical and mental wellbeing, for example, one person experiencing anxiety had recently been reviewed by the mental health team.

The home had many different changes in levels including slopes and steps with bedrooms positioned throughout the building and many people sharing bathroom and shower facilities. Changes in level were not always marked or clearly visible, which meant people could not always move safely around the home on their own. We found that some areas did not have handrails, some corridors were dark with inadequate lighting and people's rooms were not all identifiable or personalised. The largest brightest area with views of and access to the garden was used as a dining room. Two smaller narrow areas were used as lounges. Where people were living with dementia, mobility difficulties and sensory impairments the design did not aid their independence and navigation. The registered provider had not assessed the environment to ensure it met the diverse needs of people. Consideration had not been given to relevant guidance about dementia friendly environments to help people safely find their way around.

We recommend that the registered provider seeks and follows guidance, to make sure that the premises are suitably adapted to meet people's different needs.

Requires improvement

Is the service caring?

Our findings

People told us the staff were kind and caring and our observations confirmed this. One person said, "The staff are really lovely to me and very kind, they are patient and helpful." Another person said, "They are very lovely and I am fond of them." We saw frequent and consistently caring interactions between people and the staff. Staff approached people gently and used appropriate touch to reassure them. We heard staff speaking respectfully with people whilst providing care. A staff member said, "We are here for the people we care for and we put them first." One member of staff used the person's preferred name before helping them to take a medicine. The person then told us they liked to be called by the full version of their Christian name and that staff always did this. One relative told us "There are so many things you take for granted as a family member but these girls (staff) know as much about my dad as I do." One district nurse said, "The staff are very kind to people and they know them so well." One member of staff explained that one person preferred their help with personal care as they had known each other since she was a young girl. "They are like friends; I don't see them as residents. We have all grown up together so we know people, it's a family."

Records were not always stored securely. Personal records relating to people were kept in a filing cabinet in the dining room. The staff said this was usually locked when not in use. During our visits we saw this remained open even when staff were not in attendance. Therefore, people had access to private records. Some people had to walk through the staff administration area to get to their bedrooms which meant they had access to the staff handover book and noticeboard, both of which had personal and sensitive information recorded.

This meant people could not be assured that their personal information would be kept confidential.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff knew how to care whilst protecting people's dignity and right to privacy. We saw staff knocking on people's doors before entering and closing doors when they were providing care. There was a separate treatment room that was used for some personal care. One district nurse told us, "When I come to visit, staff always ask the person whether they want them to stay, where they would like the treatment done, in their bedroom or in the treatment room."

Staff said they were aware that some people preferred male or female carers and one male carer told us how he checked before helping some of the women with personal care.

The staff knew what people were able to do for themselves and they encouraged people to remain as independent as possible. They gave examples and described how people were encouraged to wash themselves, only helping where really needed. One relative told us, "They know my dad, what he can and can't do and that takes friendship." The staff also said they knew who was able to walk unaided and they encouraged them to do so for as long as possible, so they did not lose that ability. In one case they had sat with a person who was struggling slightly to move around and talked to them about what help they needed. The staff said this person was determined to remain independent so they had been keen not to offer too much help or to suggest using a wheelchair. We observed that staff encouraged this person to walk using their frame, while making sure they were safe and confident. The person told us the staff helped them in the way they needed.

People's individuality was respected. One person with equality and diversity needs was sensitively supported by staff to maintain their previous lifestyle. Another person was supported with their faith.

Requires improvement

Is the service responsive?

Our findings

People said the staff responded to their needs and provided the care they needed. One person said, "The staff always come when I ask for their help." Another person said, "I never wait long if I use my call bell". We saw that staff responded to people's call bells without undue delays. We observed that when staff were near, or in the lounge they responded to people and on occasions we saw staff anticipating a person's need without them having to ask for help and responding by providing appropriate help.

However the registered manager did not have a system for checking that call bell response times were reasonable and had not carried out any observations to ensure staff responded at all times of the day or night. The staff told us that a few people were unable to use a call bell due to their health or because they were living with dementia. They said they checked regularly on these people's wellbeing during the day and at night. There were no records to show these checks took place consistently. We observed that people, including those who lived with dementia and sensory loss were sitting in the lounge for up to an hour without staff checking on their wellbeing. When in the lounge people did not have access to call bells or another way of alerting staff to their needs.

We recommend that the deployment of staff is reassessed and action taken to ensure that adequate numbers of staff are available in all areas of the home and that people have access to a way to summon staff throughout the home.

Before people moved to the home staff carried out a basic assessment of their needs. We saw two examples and they included brief details of people's medical histories and current health. Following this assessment staff developed a plan of care describing people's needs and health. Again these were brief and they included some personalised information relating to individuals but they did not fully plan how people preferred or needed their care to be delivered. For example, one person required two staff to help them to move from their bed to a chair using a specialist piece of equipment. This was included in their plan of care, but it did not tell staff how they should carry out this procedure. Staff relied on verbal communication to make sure people's needs were met, as guidance about how to do this was not always recorded in people's care plans.

Because of this there was a risk that people may receive inappropriate or unsafe care.

Staff said they talked to each other to pass on relevant information about changes to people's health or wellbeing. The care plans had been reviewed and in some, but not all plans, information had been updated when changes occurred. The G.P and district nurses told us the staff were good at recognising when someone's health had changed or deteriorated and they responded in timely way by seeking appropriate medical attention. We heard one member of staff calling the G.P to report concerns about one person's health. They were able to clearly describe to the doctor the person's usual condition and what had changed. This showed they knew the person well and were responding to a change in their health.

We recommend that the registered provider seeks and follows best practice guidelines, to make sure that all care plans contain suitable guidance for staff about how to meet people's needs and preferences.

We found that people had limited information within their care plans about their interests, hobbies and how they liked to occupy themselves and on both days we visited we observed that people spent long periods of time with no engagement in activity. People said there were some things to do that kept them busy. One person told us about a range of recent activities including bingo, music and a trip to the shops. They said they particularly enjoyed a member of staff bringing in a puppy recently. One person told us, "I'm comfortable here but there's not much to do. I've got a TV in my room and I sit in the lounge sometimes, although the TV is always on." Another person said they would like to go out more and one other person said staff did not always have time to spend with them in their room. One visiting health professional told us, "As far as I am concerned it's a lovely home but it would be good if they had more activities, people need more stimulation and interaction." One person said, "Sometimes people come in but nothing is booked in regularly." Staff and the registered manager told us that activities were not formally planned on a daily basis. Staff said they took people out sometimes to local shops and they gave examples of when they had done this recently. Some people read the newspaper or did puzzles. We saw staff bring one person who was able to communicate well and liked to stay active, some paper napkins so they could fold these for use the next day. This person said, "I do this every day it takes me 20 minutes and

Requires improvement

Is the service responsive?

it keeps my fingers moving. I enjoy it". We observed people living with dementia and sensory loss sitting for long periods of time with the T.V on. They were either sleeping or quiet with little stimulation. Many people spent the majority of their time in their bedrooms with little to do, relying on staff to provide company or activity. During our inspection the home's lift was out of operation and had not been working for over a week. Staffing levels had not changed in order to ensure people were safe and not isolated. Records showed that the lift had regularly broken down and the home had called out engineers 75 times over five years. This meant that people with mobility difficulties and bedrooms on the first and second floors had often remained in their rooms as they were unable to get downstairs to eat their meals or socialise.

People were at risk of becoming socially isolated with little activity to stimulate or interest them in order to meet their needs or preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Relatives told us they felt welcome at any time. A small room next to the entrance could be used by people who preferred privacy and a room upstairs enabled visitors to stay overnight. One relative told us, "I keep in touch, anytime I want to come down they have been very kind to me. It may not be the Ritz but it's a lovely place." One letter received the day of our inspection said, "Thank you all once again for looking after dad so well and for making mum feel so welcome whenever she visited."

People told us they could make a complaint at any time and would feel confident speaking to the staff or registered manager. The home displayed guidance on how to complain which included timescales for responding to complaints. They also displayed contact details for CQC. The registered manager told us that although they had positioned a complaints book in the front entrance, no formal complaints had been made. They explained that they preferred to encourage an open door approach and as a result had dealt with issues as they arise. However as no records of these had been made and no residents meetings had been held since November 2014, they were unable to show what issues were raised and what action had been taken.

We recommend that the registered provider reviews how formal and informal complaints are sought and recorded. This should make sure that all complaints are recorded appropriately and that all complainants receive a satisfactory response with action to be taken.

Requires improvement

Is the service well-led?

Our findings

People and their relatives told us they knew the registered manager well and felt confident in raising any issues. One person said "Yes I see the manager all the time here, she's very kind. I really don't have any problem at all." One relative said, "They keep in contact and keep me updated." One thank you letter written to the deputy manager and staff team said, "You run a very special place." Health professionals were positive about the way the home was run and one said, "I have known the home a long time and have a good relationship with the management and staff and as far as I am concerned it is a lovely home."

Staff told us that they felt supported by both the registered manager and the deputy manager but said they did not know the provider as they had not seen them very often. The staff were not aware that the registered manager or the provider had any aims or vision for how people should be cared for. The staff said their own aim was "People come first before any paper work. We care for people and work together as a team to do that". The statement of purpose available to people was dated 2010 and contained incorrect information including inaccurate staffing and provider details. This meant people and relatives did not have up to date information which described the service they could expect or whether the staff were providing the service they were paying for.

This was a breach of Regulation 12 Care Quality Commission (Registration) Regulations 2009

The registered manager is required to notify the Care Quality Commission (CQC) of serious incidents, events and death. However no notifications had been sent to the CQC, including details about two recent deaths.

This was a breach of Regulation 16 Care Quality Commission (Registration) Regulations 2009

One staff member said "The manager does the best job she can, if we ever ask for things she does try." However we found there were shortfalls that the management team and their systems had not identified. For example, we looked at accidents and incidents records which were filed in people's care plans. The accident and incidents records were not analysed to establish patterns or trends that could inform learning and be used to improve the quality of the service people receive.

We looked at environmental risk assessments that had been reviewed by the management team. However their review had not identified that required actions had not been undertaken. For example the home's fire risk assessment required a number of actions to be undertaken but these had not all been completed. There were no records to show that the registered provider had an effective system for regularly checking the safety or the suitability of the premises.

Staff said the registered manager listened to them and acted on their views. One member of staff had suggested a new form for recording the daily care people received. This had been implemented but we found that staff had not always completed the forms. The registered manager had not undertaken any checks to monitor these and to identify areas where information was inaccurate or monitor the delivery and quality of care. The registered manager told us they were dedicated to the people and the staff team and tried their very best to lead the service. They explained how they struggled to carry out all of their responsibilities because they had no administrative support and they spent time carrying out other duties such as cooking and caring.

This meant that people who use services were not protected against the risk of unsafe or inappropriate care because the registered provider did not have effective monitoring systems in place. This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about how they sought the views of people, relatives and staff. We saw records that included questionnaires that were completed in January 2015 as well as dietary questionnaires. We saw that the registered manager had responded to issues that were raised. For example one resident had requested a day trip to the coast and this was in the process of being planned.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were at risk of becoming socially isolated with little activity to stimulate or interest them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not protected from undue restriction as assessments of people's capacity to make decisions had not been undertaken and staff had not considered whether people needed to be subject to a DoLS restriction.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The Statement of Purpose had not been reviewed or revised and provided inaccurate information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risk of unsafe or inappropriate care or treatment. Risk assessments were not always sufficient or updated appropriately to ensure that staff had clear guidance in order to meet people's needs. Medicines were not managed appropriately.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse as staff did not understand their responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider had not effective systems in place to ensure the home was maintained to an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The registered manager and provider had failed to submit notifications of deaths.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People could not be assured that their personal information would be kept confidential. People were not protected against the risk of unsafe or inappropriate care because the registered provider did not have effective systems in place for monitoring the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The registered provider failed to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people.

Staff were not provided with appropriate support and supervision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Safe recruitment practice had not always been carried out.