Mrs W L Bellett

Stoneham House

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and took place over three days, on 15, 16 and 18 June 2015. We met with the registered manager and the owner on 29 June 2015 to provide further feedback as the registered manager was not on duty by the time we had completed our visit on 18 June 2015.

At our previous inspection in March 2014 we found standards were not being met and there were breaches in regulation in four areas. These were: In the care and welfare of people who use the service; in the management of medicines, in supporting workers and because the service had not notified us of significant events. The detail of this is published on our CQC website.

The provider submitted an action plan in May 2014 which explained how they were going to meet these shortfalls. They said these were going to be addressed by 1 June 2014.

At this inspection we found although some improvements had been made, there continued to be breaches in regulations which related to the care and welfare of people, the management of their medicines, in how staff were supported and in the reliability of the provider to notify us of significant events. There had been a change in legislation since the previous inspection. Regulations breached in April 2014 under The Health and Social Care Act 2008 (Regulated Activities) and The Care Quality Commission (Registration) Regulations 2009

Summary of findings

continued to be breached at this inspection which was conducted under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

We found further shortfalls in all areas we looked at during this inspection.

Stoneham House is a private residential care home without nursing set on the outskirts of Southampton. It is registered to provide accommodation and care for up to 37 people who may be living with dementia. On the days of our inspection visits 12 people were living there.

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.

People were not safe because there were not suitable arrangements in place to manage medicines. The registered manager and staff did not take appropriate action when people were experiencing abuse or when abuse was a possibility, for example when people had carpet burns or unexplained bruising. As a result of our inspection we reported a number of events where people were at risk to Hampshire County Council under safeguarding procedures.

Risks to people were not appropriately assessed and so action had not been effective in reducing the chance of accidents or incidents happening again, for example for people who had fallen out of bed.

Although staff had received some training in subjects relevant to their role, this had not been translated into practice and staff did not receive adequate support to ensure they carried out their jobs effectively.

People were not always asked for their consent before care and support was given and people's wishes and views were not sufficiently heard or considered.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes where people's liberty or freedoms were at risk of being restricted. This had not always been taken into account.

People did not receive appropriate support or advice about their dietary needs and those that needed assistance to eat were not given appropriate help.Health and social care professionals had offered advice about people's health and care needs but this advice had not always been followed and their assistance at times had been refused.People's comfort and dignity was not always considered. Some people spent most of their days in wheelchairs and looked uncomfortable. The registered manager acknowledged this but had done nothing significant to address this.

People's care records were not personalised and did not reflect people's actual needs and preferences. The service did not have a robust management structure and staff and the provider deferred to the registered manager in all matters relating to the care and welfare of people. The registered manager had not always acted in an appropriate or timely way to ensure people were being well and safely cared for.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. CQC is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 getting their medicines reliably and safely and they were not being properly protected from possible or actual abuse.

People's individual risks were not being assessed appropriately so they were not being cared for as safely as possible.

Although there were sufficient numbers of staff, they did not have the right skills and experience to meet people's needs.

Is the service effective?

Inadequate

The service was not effective

Staff were not sufficiently trained or supported to provide effective care.

People's consent to care and support was not always obtained.

People were not always offered effective support at mealtimes or effective advice if they had particular dietary needs.

The staff and registered manager did not liaise effectively with healthcare professionals and did not consistently act upon issues identified.

Is the service caring?

Requires improvement

The service was not always caring

Whilst we saw some caring interactions there were shortfalls in the caring attitude of staff and the registered manager.

People were not always treated with kindness, respect and compassion.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care and support in line with their needs and preferences.

The environment was not well adapted for people with mobility problems or for people who had a cognitive impairment.

There was a complaints process, although complaints received had not always been documented.

Is the service well-led?

Inadequate

The service was not well led

There were significant shortfalls in the way the service was led, which meant people received care which was not safe, effective caring and responsive.

Summary of findings

The aims of the home were to “preserve the dignity and privacy of our residents” However people’s privacy and dignity were not always respected.

Stoneham House

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 unannounced inspection took place on 15, 16 and 18 June.

The inspection team was made up of four inspectors in total. Two inspectors visited on each of the days of our visits. Before our visits we had received information of concern from two social care professionals and we reviewed notifications sent to us by the service. Registered services must notify us about certain changes, events or incidents which happen in the service.

During our visits we spoke with all twelve of the people who lived at Stoneham House, we spoke with four visiting relatives, four staff, the registered manager and the owner. We observed interactions between people and support being provided in communal areas. We looked at four people's care and support records in detail and at some records relating to the care and support of all the other people living at the service. We also looked at three staff records and the diary of the service. We looked at documents relating to the home such as staff training records, staff rotas and quality assurance audits.

During and following our visits we shared information under safeguarding processes with Hampshire County Council. This related to five people who were living at the service. We also contacted Hampshire fire service to clarify whether there were effective fire safety arrangements. After our visits we were in contact with social and health care professionals and received feedback which raised some further concerns.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2014 we said people were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines within the home. This related to the way medicines were disposed of and the records of creams being administered. Although disposal systems had improved and creams were being signed as being given for we had further concerns regarding the management of medicines. Medicines were not always administered as prescribed. When we asked a person how they received their medicines they said "it seems a bit haphazard, some days you get more than other days"

During the evening of 16 June 2015 we observed a person had a pot which contained medicines on their bedside table. The person was not aware they were there until we pointed this out to them as their sight was not good. This was the person's morning medicines. Records showed they had been signed for as given that morning by the registered manager. Staff said there was no policy in place regarding missed medicines but said they would talk with the registered manager. The registered manager was not on duty at the time. We advised staff they should contact the out of hours doctor to check whether any action was needed with regard to the medication error. This was important because Stoneham House does not provide nursing care and it was necessary to establish what, if any, additional support the person might need because of their missed prescribed medicines. A message was left in the diary the following morning for the registered manager to say staff had tried to do this they but had not received a reply when they rang the GP. No other action was apparent. The registered manager said during our meeting on 29 June 2015 they had subsequently discussed this with the GP. They agreed no action had been taken at the time.

Another person who needed staff to support them with medicines had asthma according to their records. They had been prescribed a salbutamol inhaler to help to manage this. Records from a GP in December 2014 said this should be taken 'as required'. There was no guidance for staff about when this should be given. Medication administration records (MAR) checked for June 2015 showed the person was prescribed this four times a day. This had not been marked 'as required.' The person had not been given this medication at all on the MAR chart which commenced 25 May 2015. We observed this on 18 June 2015.

We referred both people to Hampshire County Council under safeguarding protocols because they had been put at risk as they had not received their medicines as prescribed.

On 15 June 2015 we observed the lunchtime medicines round which was carried out by the registered manager. Medicines were dispensed from 'nomad' packs supplied by the local pharmacy. Each person's medicines were tipped into a plastic pot. The same pot was used for each person's medicines. This meant people's medicines could be contaminated from the previous medication.

On 15 June 2015 we observed a staff member administering a homely remedy to a person living at the home. The homely remedy was brought in by a relative of the person. We asked to see where on the MAR chart the remedy had been recorded. It had not been recorded. The registered manager said he did not know it was being given. We found the bottle in the person's room on the bedside table, it was almost empty. This meant a medicine had been bought into the home and was being administered to a person without being recorded and without the manager's knowledge. The manager had previously told us homely remedies were not allowed in the home.

Medicines were correctly stored, including those which needed to be stored in a fridge. There were photographs of people on the front page of the MAR chart folder which were used for identification purposes. There was a specimen chart of staff signatures for staff who administered medicines. The manager told us medicines were reviewed by the hospital or person's doctor as necessary and a record of medicine reviews was kept in the folder.

At our last inspection in April 2014 we said the service did not have Personal Emergency Evacuation Plans (PEEPS) in place. Under current fire safety legislation it is the responsibility of the person(s) responsible for the building to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be in the premises, including disabled people, and how that plan will be implemented.

Inadequate

Is the service safe?

We shared information with Hampshire Fire and Rescue service as we wanted to be sure arrangements for people were safe in the event of a fire. They visited and found fire safety arrangements were appropriate.

At our last inspection in April 2014 we said people's individual risk assessments were identical. At this inspection we continued to find risk assessments did not reflect people's particular needs. The risk assessment process for individuals is about identifying and taking sensible and proportionate measures to control the risks to people's health or wellbeing. The registered manager had devised risk assessments for all people living at the service but he did not demonstrate a good understanding of the rationale behind assessing people's individual risk. This meant risk to people's wellbeing had not always been appropriately assessed and measures therefore had not been put into place to help to keep people as safe as possible.

Some people had fallen out of bed on more than one occasion but there was no assessment of what action could or should be taken to reduce the risk of reoccurrence. Generally, no action had been taken following a fall out of bed other than an additional mattress had been made available at the side of some people's beds and the person was checked for cuts and bruises, (which were recorded on a body map) and then they were returned to bed. There was no additional monitoring of the person afterwards and no consideration of whether they were in pain as a result of their fall. This put people at increased risk of physical harm and discomfort

Risk assessments were not person centred or proportionate. One said for example "It is possible that (the person) may sit down while walking because of an epileptic fit", it went on to say "no one not even (the person) knows if they are going to sit down because of a fit" This did not give staff any guidance about how to support this person. This meant staff were not in a position to keep people as safe as possible.

Everyone in the home had a risk assessment relating to drinking the alcohol gel used for hand cleaning. The alcohol gel was located in the main entrance of the home and in a staff area. This had been raised as an example of inappropriate risk assessment at our previous inspection in April 2014. The registered manager had put in place a risk assessment for alcohol gel for everyone as he said "when confused many of our residents have attempted to drink shampoo and bubble bath so we feel there is a risk they will drink the gel without controls". We discussed this with the registered manager as this was not person centred and it evidenced the registered manager's lack of understanding about what the risk assessment process was for.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1) and (2)(g) and 2(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not demonstrated the proper and safe management of medicines. The provider had not done all that was reasonably practical to mitigate risk and assessments did not always contain plans for managing risks.

People were at significant risk of harm because although staff had received training in safeguarding adults they had not put this knowledge into practice. Staff said they would discuss with the registered manager if they had concerns about people's safety. However staff and the registered manager had not followed safeguarding procedures in a timely way to keep people safe.

When we found the untaken medicine on a person's bedside table we told staff they needed to report this to Hampshire County Council as a safeguarding referral as there was a risk the person was not receiving their medicines as prescribed. According to their care records there were additional risks associated with this. At this time the owner and two staff were present. The owner and staff did not understand how to make this referral. The owner said that it was the registered manager's responsibility and said he would deal with it in the morning. We explained that safeguarding matters should be reported without delay and asked staff and the owner where the out of hours number for Hampshire County Council was. They were unable to find it without considerable effort and our help. We made the referral ourselves as we could not be confident they knew how to do this.

On one of the days of our visits we observed a person living at the home became verbally abusive towards a staff member. This occurred in the lounge in the presence of other people who lived at the home. We discussed this with the registered manager. He said this person was often verbally abusive towards staff and also towards people who lived at the home. There was no guidance for staff about what to do in these circumstances. We heard one person living at the service had been upset. At teatime on

Inadequate

Is the service safe?

the same day they said (this person) “scares me, he scares me a lot.” We asked the registered manager if he had reported this to Hampshire County Council as a safeguarding referral as people at the home were being verbally abused and he said he had not. He said if anyone had been upset by this he would have done so. We reported this to Hampshire County Council as a safeguarding referral.

Care records for one person contained three body maps which recorded bruising to the person’s body. Over a period of eight and a half months in 2014 different staff had recorded at different times; nine areas of bruising, an old skin flap and four marks described as carpet sores. Some marks corresponded with a fall out of bed. This included the four marks described as carpet sores. The registered manager was unable to explain why this person would have carpet sores as a result of a fall. This had not been reported to Hampshire County Council as a safeguarding referral. In November 2014 a body map record showed this person had four small bruises on their right inner arm. We showed this body map to the registered manager and discussed whether these could be finger marks. He said “it’s possible”. This had not been reported as a safeguarding issue so we reported this to Hampshire County Council.

A different person had been recorded as having a ‘carpet burn’ after a recent fall. We reported this to Hampshire County Council as a safeguarding referral.

Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. This was a breach of Regulation 13 (3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our visits there were twelve people living at Stoneham House. They were supported by the registered manager who worked Monday to Friday, The registered manager was contactable when they were not in the building. The owner, who lived in the premises, worked as part of the staff team. Staff rotas showed there were two care staff on duty during the day from 8am to 8pm and there was one waking night staff who was on duty 8pm to 8am. The owner was on duty as a sleep in staff every night and provided extra support where necessary. There was a cook every day and a member of staff dedicated to cleaning six days a week. Staff interchanged their roles but said if they were cook or cleaner they did not provide care. Although there were sufficient staff deployed to meet peoples’ needs we were not satisfied staff had the right mix of skills competencies and experience to meet people’s individual needs. The owner said some staff didn’t understand what was required even when this had been explained to them. We were concerned that staff, who needed considerable support, had been left in charge of shifts at times. This had led to inappropriate action being taken on one occasion to protect people who lived at the home.

Inadequate

Is the service effective?

Our findings

At our last inspection in April 2014 we said staff did not receive regular supervisions and they were therefore not supported to deliver care to an appropriate standard. We said staff did not receive essential updated training. The registered manager wrote to us and said these improvements would be completed by June 2014.

At this inspection staff said they received support from the registered manager. They said they had received regular supervisions and had completed training in areas appropriate to their role. Despite this, staff were not aware of key processes about how to keep people safe and how to protect their rights. Some staff did not understand how to make a safeguarding referral to Hampshire County Council. (HCC). The registered manager had recently been asked about staff competencies by HCC. This related to concerns HCC had about people not being properly supported to eat and people not being helped to move safely. The registered manager had responded to HCC saying he had seen all staff about pushing food into people's mouths and said staff had been instructed not to pull people by the arms. During our visits we did not observe anyone being pulled by their arms but we did observe staff not giving people sufficient time to eat. These concerns showed training and guidance had not been embedded into practice.

Staff did not always have the skills to communicate effectively so they could carry out their roles and responsibilities. A health care professional said "The care staff do not always appear to know the residents, they bring out the wrong notes and take us to the wrong residents." We observed there were times when staff sat in the lounge apart from people, not interacting and times when staff spoke with each other in their native language in the presence of people living at the home.

Although there was some monitoring of people's health needs, staff had not always acted on issues identified or worked cooperatively with health care professionals Staff had not requested medical advice in a timely way following missed medicines. Health care professionals said staff had not always followed advice given, for example, about the correct settings for pressure relieving mattresses. Staff had not consulted with specialist health care staff, for example occupational therapists where this could have improved the quality of people's lives despite this service being offered to them.

Some health care professionals described difficulties in working with the registered manager. They said for example "When we visit the home (the registered manager) makes us all feel very intimidated, he gets very defensive if we try to offer advice". This meant people might not have had the best possible outcomes and their health could deteriorate.

This was a breach of Regulation 12(1) and 12 (2) (c) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not have the competence, skills and experience which are necessary for the work to be performed by them and the provider was not working with others to make sure people's care remained safe.

We observed at times staff asked people for their consent before they provided support but this was not consistently done for example; people were moved in their wheelchairs without explanation of where they were going or why. Although records showed staff had completed training in the Mental Capacity Act 2005 they were unable to explain how they sought people's consent and how they involved them in decisions about their care

The primary purpose of the Mental Capacity Act 2005 is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. At Stoneham House people's capacity to consent to aspects of their care had been assessed. However their capacity to make fundamental decisions about their lives had not been properly considered. For example one person was unhappy to be living in the home and said "There's nowhere to go. It's like living in a prison, it's so isolated here. I'm marooned". This person's views and capacity to consent to this major decision in their life had not been properly taken into account. Another person said "I can't go out on my own anymore, I'm not allowed"

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if they lack capacity to consent to their care any restrictions to their freedom and

Is the service effective?

liberty have been agreed by the local authority. For people assessed as not having capacity to consent to their care we did not see any evidence application had been made to the local authority under DoLS

This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the registered person was not ensuring care was provided only with the relevant consent or if a person was unable to give consent because they lacked capacity to do so, they were acting in accordance with the Mental Capacity Act 2005.

We looked at how people were supported to have sufficient to eat drink and to maintain a balanced diet. Social care professionals told us that recently when they had visited (on separate occasions) two people had told them they were hungry.

We observed people were provided with drinks and snacks regularly throughout the day. However people were not always supported effectively to eat their meals. In the dining area one person had a bowl of soup in front of them at their table. After ten minutes a staff member removed the bowl of soup without asking the person if they had finished. During this time we did not see the person eat any of their soup. Later we observed one member of staff sit beside the same person to encourage them to eat a sandwich. They were not given sufficient time to chew and swallow each mouthful as the member of staff placed the sandwich on their lips whilst they still had food in their mouth.

Social care professionals told us they had also witnessed a person having more food put in their mouth before they had finished eating. This had put them at risk of choking.

People had nutritional care plans which were written by the registered manager. Some people at Stoneham House had particular nutritional needs because they were diabetic. One person's care plan said "A dietary plan for diabetes would follow the principles of healthy eating. (the person) should continue to eat normally" It did not however detail what the principles of healthy eating were. This person had sugar on their breakfast cereal in the morning. They said "I don't suppose I should, if I have diabetes should I"? This person had not had healthy options explained or offered to them to enable them to make lifestyle choices if this was their wish.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people had not received appropriate support to meet their nutritional needs.

Requires improvement

Is the service caring?

Our findings

People who lived at Stoneham House who were able to say were largely complimentary about the staff. They said "Staff are very polite, but they don't say much". Another said "It's very easy going here." This person spent most of their time in their bedroom. They said the registered manager talked with them every day and staff talked with them when they had the time. Another person said "The staff are very kind, but they haven't got time to talk to me". Visitors said "It's just like one happy family" and "Everyone is so kind" Other relatives described staff as friendly and felt staff knew people who lived at Stoneham House well. The registered manager demonstrated a good understanding of people's backgrounds and interests and talked with them about these in a friendly way.

Some people were not able to tell us their views about how caring the service was so we spent time observing how staff interacted with people. We saw some kind exchanges, for example one staff member walked alongside a person on the patio at a slow pace, encouraging them, reassuring them and picking a flower for them to look at.

There were other times when people did not receive kind and compassionate care. Staff sometimes performed tasks without talking with people, for example putting on or removing aprons at mealtimes and moving people in wheelchairs without explaining why they were doing this or where they were going. People's dignity was not always upheld, for example one person who could manage to eat their own meals had not been provided with any adapted equipment to enable them to do this with more ease. One visitor said they had been present when people were being weighed in the lounge. The registered manager agreed this was where people were weighed and said he treated it as a "bit of fun." People had not been asked if they were happy with this arrangement. One person needed glasses but they were not wearing them on the first two days of our visits. We asked staff towards the end of our second visit if this person wore glasses and they said they didn't. The owner overheard and corrected this. On the third day the person was wearing glasses and appeared more engaged with things going on around them.

Three people spent much of their day in wheelchairs. They did not appear comfortable and when we asked them if they were, one person said "No" and looked distressed. The registered manager agreed that people did not always appear comfortable in their wheelchairs but had not taken action to try to improve this; apart from ensuring one person had a rest in their bed every afternoon.

Although records showed staff had completed some training in infection control we did not find staff always understood their roles and responsibilities in relation to infection control and hygiene. We observed one member of staff holding a sandwich directly on a person's lips encouraging them to eat. After the first mouthful the member of staff placed the sandwich on the plate and went to another table. Whilst wearing the same gloves the member of staff picked up a napkin and wiped another person's mouth and nose, removed the person's apron, picked up their plates and took them to the trolley. The member of staff returned to help the original person to eat her sandwich wearing the same gloves.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) as people were not treated with dignity and respect at all times.

There was some conflicting evidence about how much people were involved in the planning and delivery of their care. The registered manager said people and their families were consulted about the help and support they needed. Care plans had been signed to indicate people's agreement. However, we discussed one person's care plans with them. They disagreed with some of the information which had been written about them.

Staff said people got up and went to bed when they wanted to. One person confirmed they could have a meal in their room if they wished to do this. One person did not want to be checked at night and this was respected. Everyone else was checked every two hours during the night. It was unclear whether they had been consulted about this.

Visitors were made welcome and there was a second lounge available for people to visit in private if they wished. They said they were kept informed of any changes to their relative's health or wellbeing.

Inadequate

Is the service responsive?

Our findings

At our previous inspection in April 2014 we found people did not experience care and support that met their needs and protected their rights. We said people's care plans were not personal to them, and there were no PEEPS (Personal Emergency Evacuation Plans) in place. At this visit PEEPS were in place. Care plans had been updated in June 2015. However we continued to find the service was not responsive to people's individual care needs. People's care plans were not personalised, monitoring was not accurate and people's needs were not always accurately described.

There were written assessments of people's care and support needs. People's needs had been assessed for example in terms of their personal care and physical wellbeing, diet, medication, mental state and cognition. However this information did not always help staff to deliver care which reflected people's needs, choices and preferences. An example of this was staff told us one person preferred to be supported by female staff. We witnessed this person becoming upset when a male member of staff tried to assist them. We asked the registered manager about this. They said this person had not had a problem with him. The owner confirmed the person preferred female staff to assist them. There was no written guidance for staff about how to effectively respond to this person's needs and wishes.

Other people's care records did not give a clear picture of their needs. For example, one person's care records said they had not had an epileptic seizure for a number of years. However we received a notification of a serious injury to this person in April 2014 which said they were found on the floor and it stated the person "may have had an epileptic fit as he is a known epileptic." The contradictions in this information increased the risk of staff not being able to provide appropriate care and support.

People or their relatives had signed care plans to indicate they agreed with their content. We discussed a person's care plans with them, they agreed some aspects were accurate, however described other parts of their care plan as "complete fabrication." Their care plan said for example they liked to have a strip wash themselves every morning. They said they could manage to wash their own hands and face but couldn't manage anything else. The care plan said they would like to cut their own fingernails The person said "I wouldn't be able to see properly. I ask them (staff) to do it. It's not a problem". The person's care plan also said they would like to be offered a cooked breakfast every day. They said "That's an invention, I've had bacon and eggs a couple of times and been very grateful. I've never asked for it."

Monitoring of people's care needs was not carried out consistently. This made it difficult for staff to ensure people's continued wellbeing. For example, one person's plan said "We will record bowel movements and if (the person) has not been for two days, which is normal for her, the district nurse will be contacted". Bowel movements were recorded on daily records. We looked at this person's daily records from 7 June to 13 June 2015 and these stated the person had not had any bowel movement during this time. We found no records to show the district nurse had been called. We brought this to the attention of staff who told us this person did have bowel movements during the dates stated.

Social care professionals had conducted a number of care reviews with people at the service and also commented care plans and records were not an accurate reflection of people's care needs and wishes.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the provider had not done everything reasonably practical to make sure people received personalised care that was appropriate, met their needs and reflected their personal preferences.

We asked people what they did during the day. They said "The most activity I do is talk to the person next to me" and "I like going out, now I just sit here". This person said "Can I spend some time away from here?" but they did not say any more about what they meant by this. One person said they tended to stay in their room as when they went downstairs the person they spoke with kept going to sleep. They said they nearly went out once for a drive to the New Forest but there were too many people going so there was no room in the transport. A visitor said their relative had enjoyed a visit to the New Forest but said "they could get out more".

The registered manager led activities some mornings and we observed them in the lounge with nine of the people who lived at the service. They were playing music such as Doris Day and Elvis and talking with people about this. One person said "I like the music" and we saw another person was tapping their foot in time with it. After a while the

Inadequate

Is the service responsive?

registered manager said “we have had enough of this now” and asked people around him which channel whey wanted to watch on the television. The television remained on for the rest of the day although few people seemed to be watching it.

Some people in the home had a cognitive impairment due to their dementia. There were clear guidelines in people’s care plans about how to communicate with people but we did not see this put into practice. This resulted in people not always being offered choices in their daily lives. For example we observed one person moving fruit around in a bowl at the end of their meal. They had five segments of satsuma in front of them and appeared engaged in looking at them and feeling them, whilst trying to place them back in the bowl. A member of staff came and took these away. We said we did not think the person had finished with them. They brought the fruit back and popped a segment of satsuma into the person’s mouth without saying anything and walked away. The person immediately made an unhappy face and took the piece of fruit out again.

The environment was not very well adapted to help people living with dementia. There was little signage around the building to help people navigate their way around, no use of colour to help people identify different areas or rooms and some corridors and rooms were poorly lit. Staff said they had received training in dementia care although there was little evidence this was put into practice. The environment was also not very well adapted to people with mobility problems. For example, there were no rails for people to hold onto in the downstairs foyer. We observed one person moving around this area holding on to the stair bannister and holding the walls. They generally walked with the assistance of a frame but they were not using this. The person did not look steady on their feet and we assisted them twice by giving them an arm to help them to where they were going.

The registered manager said they had not had any complaints. We were aware however some complaints had been made by social care professionals which had not been recorded. One visitor said they had not had to make a complaint but would talk with the registered manager if they had any concerns. One person who lived at the service said they did not have any complaints but they not aware of the complaints procedure they said “I suppose I would talk to Peter?”(the registered manager). We asked for this person to have a copy of the complaints procedure and this was provided to them.

Inadequate

Is the service well-led?

Our findings

The service was not well led and had widespread and significant shortfalls in management.

There was a registered manager in post. The owner was actively involved in the running of the service and knew people's needs but she, and staff deferred to the registered manager in most matters regarding people's care and welfare. We asked the owner how the service operated when the registered manager was on annual leave as we felt the management structure was fragile. They replied the registered manager "does not have leave". We discussed this with the registered manager who said the two people they had in mind to deputise were not able to do so at that time for different reasons.

People living at the service depended upon the registered manager to take timely and appropriate action to keep them safe and ensure their needs were being met. However the registered manager had not always managed the service well. There were not sufficient procedures in place for staff to follow if they needed guidance about what to do, for example, if a person had not taken their prescribed medicines. They had not always followed advice from health care professionals or accepted support from health care professionals when it had been offered. This put people at increased risk because professional input may have provided advice, guidance and equipment to increase people's safety and comfort. The registered manager had not reflected accurately risks to people and had not taken appropriate action to minimise the chance of these risks happening again, for example, for people who had fallen out of bed. This put people at an increased risk of harm. They had not ensured people received their medicines as prescribed. This put people at increased risk of harm. Safeguarding concerns had not always been referred to Hampshire County Council when they should have been. CQC were similarly not notified. We had identified at our previous inspection the service had not notified us of significant events and they were still not doing this for some instances of possible abuse.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the service was not following agreed protocols and there were no balances and checks in place to ensure appropriate care and support was being given.

People and staff were not actively involved in developing the service. Staff had some knowledge about how to care for people in an appropriate way, for example, they knew one person who lived at the service reacted better to women staff than to male staff, but this had not been taken into account by the registered manager in the planning and delivery of this person's care.

There were quality assurance processes in place. The registered manager and owner completed a monthly report about the service. The most recent one we saw was completed in May 2015. This included the opinions of people who lived at Stoneham House and staff views about the service. All were positive. There were also a number of audits of the service for example, there were monthly checks on reports of accidents and incidents within the home. However neither the monthly report nor the audits picked up the issues which we have described in the other sections of this report. The service had not addressed all of the breaches in regulation described in our report of April 2014. This meant the quality assurance processes in the home were not effective.

An information sheet was available about Stoneham House. This was designed for prospective residents and for people showing an interest in the home. It said "We aim to preserve the dignity and privacy of all of our residents" We observed and were told of situations when people's dignity and privacy was not being maintained , such as when staff did not support people properly during mealtimes and when people were being weighed in the communal lounge. Simple things which could have improved people's day to day experience were not done, for example staff did not ensure one person was wearing their glasses which meant they were not able to see as well as they could have done. Some people spent most of their days in wheelchairs and they were clearly not as comfortable as they could have been. The registered manager was aware of these issues but had not taken any action to improve this.

A number of professionals had raised concerns about the management of the home. Social care professionals had found the registered manager at times to be unhelpful. We found the registered manager was not consistent in their information. An example of this was when we provided detailed feedback about our inspection to the registered manager and owner on 28 June 2015. We discussed one person who had been upset by another person's behaviour. We provided this person's name. The registered manager

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said there was not a person by that name at the service. There were only 12 people living at the service at this time. At the end of our meeting the registered manager acknowledged there was a person of that name who lived at the service.

This meant the service was being led by a person who had failed to manage it in a safe, effective and responsive way. There was no back up to this management and there were no reliable quality assurance systems in place as these were carried out by the owner and the registered manager and both had failed to identify clear shortfalls in the provision of people's care and welfare.

This was a breach of Regulation 17(1) and (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have systems and processes in place to enable them to identify and assess risks to the health safety and welfare of people who used the service.