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

Summary of findings

Overall summary

The inspection took place on 8 March 2017 and was unannounced. A further visit took place on 17 March 2017 to continue with the inspection. We returned on 7 April 2017 to meet with the provider as since our previous visits the circumstances of the service had changed as the registered manager had left and we had received new information of concern. We shared information with Hampshire County Council who commission care at the service and who take the main lead in safeguarding people living at the service. Since our meeting with the provider on 7 April 2017 we received further information of concern and so visited the service again on 22 May 2017 and 25 May 2017. When we visited in March 2017 the evidence we gathered reflected a service which had continued to make some improvements.This report reflects evidence from all of these visits but focusses more on evidence gathered during the visits in May 2017 and information gathered following our visits in March 2017 as this more accurately reflects the current position of the service.

We last inspected the service in December 2015. At that time we found significant improvements had been made since our previous inspection in June 2015 but we judged the service required improvement overall.

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. At the time of our most recent visit in May 2017 there were 14 people living at the service.

At the time of our visits in March 2017 a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers; they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our visits in April and May 2017 the registered manager had left and the service was being managed by an acting manager who knew people living at the service well.

Our main concern was the lack of structure within the service. Since the registered manager had left some of the provider's family had taken over aspects of management, but they did not have the skills or experience to do this effectively. This meant for example, accountancy processes were unclear and responsibility about who should conduct audits of the service was vague. It was not clear who should be responsible for each aspect of the service.

There were not sufficient staff employed with the right skills and experience to lead a shift safely. Risk to people's care and welfare and environmental risk was not always properly addressed. The environment was excessively hot and some rooms had a malodour.

People were not always provided with care which focussed on their needs and wishes. The procedure to

address complaints and safeguarding concerns was not robust. The culture of the service was not open and inclusive which meant staff did not always report or act upon concerns in a timely way.

We did however witness kind and caring interactions by staff and activities provided had improved since our last visit.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

There were eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the 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 the report.

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.

The service was not following policies and procedures to safeguard vulnerable adults. Risk to people's care and wellbeing was not being consistently addressed and environmental risks had not been identified and managed in a timely way.

Medicines management was generally safe but there were not sufficient trained staff on duty at all times to ensure people could always be given their medicines when they needed it.

There were not sufficient numbers of suitably trained and skilled staff employed to ensure the service met the needs of people consistently.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have the knowledge and skills necessary to carry out their role and responsibilities. Whilst staff asked for people's consent before they provided support they needed more understanding of the requirements of the Mental Capacity Act 2005. People liked the food but nutritional needs were not always fully understood or addressed. Changes in people's health care needs were not always followed up in a timely way.

Is the service caring?

Requires Improvement

The service was not always caring.

Some aspects of the environment were poor which meant people were not always treated with dignity and respect . Although we witnessed kind and caring interactions there was not always prompt action taken to relieve people's discomfort. Privacy was respected.

Is the service responsive?

Inadequate

The service was not responsive

People did not always receive personalised care which was responsive to their needs .The concerns and complaints process was not robust.

Staff supported people to take part in activities.

Is the service well-led?

Inadequate

The service was not well led.

The service was not open and inclusive.

Quality assurance systems were ineffective. There were insufficient resources and support available to drive improvement.

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.

The first inspection visit took place on 8 March 2017 and was unannounced. The inspection team consisted of an expert by experience and an inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned on 17 March 2017 to gather further evidence. We received information of concern after our visits in March 2017 so an inspection manager and an inspector returned to the service on 7 April 2017 to meet with the registered provider. Two inspectors visited again on 22 and 25 May 2017. These visits were to review and update our initial findings as we had received further information of concern.

During our inspection we talked with ten people who lived at the service and observed the care of others in communal areas when they were not able to verbally provide us with feedback. We spoke with seven relatives and spoke or received feedback from a further five relatives following our visits. We spoke with one health care professional and with three social care professionals to gather their views about the quality of service currently provided. We looked at the care records for seven people as well as other records relating to the management of the service such as six staff files, policies and quality assurance records.

Inadequate

Is the service safe?

Our findings

When we asked people and their relatives if they received safe care at Stoneham House their opinions varied. Some said they did. One person for example said. "I feel safe here. That's part of it. I used to keep checking the doors and windows at my house". Relatives said they had been given the code number for the front door. One said this gave peace of mind as it indicated the service was always accessible as "no one has anything to hide". Three people said they had lost confidence in the ability of the service to provide their relative with safe care as their concerns and complaints had not been properly addressed.

Most people said there were sufficient staff on duty to meet their needs although some people told us they were worried their call bells were not answered promptly and this caused them some distress. Delays in responding to call bells were an important issue for people living at the service.

When we visited in May 2017 there were 14 people living at the service. People were supported by a minimum of three care staff during the day and by two waking night staff. Care staff were assisted by a full time activity coordinator and by domestic staff. Where there were shortfalls in the staffing rota the service employed agency care staff. Staff we spoke with said there were generally sufficient staff on duty to meet people's needs. One said "sometimes we are rushed off our feet, other times we have time to sit and chat. On balance staffing levels are right."

Despite feedback from staff, there was a lack of competent and skilled staff to meet people's assessed needs. There were not sufficient senior staff to lead shifts effectively. When we visited in May 2017 staffing personnel had undergone some changes. The registered manager had left and whilst we observed staff to be willing and kind in their interactions with people, we had concerns about their ability and experience to take responsibility to manage shifts.

Staff rotas in May 2017 showed the acting manager, who acknowledged she needed some support to manage the service, had one senior care staff to support her regularly during the day. This staff member had been employed for nine weeks. They had been provided with very limited induction training. There were two senior staff employed during the night. There were four regular care assistants and one bank staff employed to support the senior staff. Agency workers, most of whom had worked at the home before and so had some knowledge of people who lived there were employed to fill in the staffing shortfalls.

The impact of this was that there were not always staff able to lead a shift who had the skills and experience necessary to support people effectively and safely. Examples of this were staff did not always know who to report safeguarding issues to and so this meant they were not reported or acted upon in a timely way. Sometimes there were no staff on duty trained to administer medicines. When this happened, trained staff or the acting manager were called in to complete the medication rounds. Although this covered people's general needs as they received their prescribed medication it meant there would be a delay in people receiving PRN (as required) medicines for example for pain relief when there were no staff in the building on duty to administer it.

The provider said there was always one regular member of staff employed at night. However during the time of our visits, one member of staff had needed to take time off unexpectedly. There were insufficient other regular staff to fill the gap. This resulted in the provider working a night shift with an agency staff one night and the next night two agency staff were employed.

There were not sufficient and suitable people deployed to cover both the emergency and the routine work of the service.
This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment was not robust. Staff records contained some of the necessary documentation to help to ensure the service was following safe recruitment procedures including, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK. There were, however some gaps in staff recruitment records as, for example, requests for references had not always been followed up when they had not been received. When we visited in May 2017 staff documentation was incomplete. Staff were unable to access electronic records and paper records did not contain the required information regarding recruitment or information about any training that had been completed by staff. Staff were unaware of what information was missing. This meant the service could not demonstrate safe recruitment procedures were being followed.
This was a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as recruitment procedures must be established and operated effectively to ensure suitable staff are employed.

Risk assessments were incomplete and put people at further risk of harm. At our last inspection in December 2015 we said written assessments of risk to people's health and wellbeing were general and did not always relate to people's specific needs. During this inspection we found there were still some risks to people's health and wellbeing which had not been addressed. One person had three falls in a ten day period in November 2016. They had been referred to a falls clinic. In May 2017 staff could not confirm any subsequent actions which had been taken to chase up this referral. A record had been kept which described the falls this person had had, but this did not detail possible causes or future preventative measures. The person was assessed monthly for risk of falls. Their risk score had increased in April 2017 as they had further falls, however, there was no record of actions taken as a consequence.

One person had bed rails. There was a risk assessment in place saying, 'bed must be at lowest point, put rails up when he is in the bed, check on him hourly, put sensor mat at the centre of bed.' The person's bed was not an adapted bed and could not be positioned close to the floor. Their mobility care plan said the person was fully independently mobile. Staff told us that the rails were a preventative measure to stop them from getting up and falling. It was discussed at a handover meeting during one of our visits that the person had been found trying to climb over the bedrails, which put them at greater risk of harming themselves. Staff could not confirm that any best interests assessment had taken place around this decision. Staff were not aware of safety concerns around bedrails and told us a doctor had instructed them to do this.

A lack of information left people at risk of harm. One person had recently developed epilepsy. There was no mention of this in their care plan and so staff did not have guidance about how to care for this person in a safe way. Staff we spoke with were aware of the person's condition but health care professionals had raised concerns about how staff had responded meet this person's health care needs.

Environmental risks had not been addressed. We observed broken and unstable furniture which was located in communal areas, such as a broken chair in the dining room, a wobbly over chair table in the lounge and a

wobbly seat in the conservatory. We discussed with staff that some furnishings were not suitable and some had been removed by the time of our following visit.

The risk of legionella had initially not been updated. Staff did not follow actions identified to mitigate risk until an environmental health officer visited to provide advice.
This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered person must assess the risk to the health and safety of service users receiving care and do all that is reasonably practical to mitigate any such risk.

Staff lacked understanding of how to safeguard people. Not all staff had received training in how to safeguard adults, including those leading shifts and this meant they did not always recognise signs of potential abuse or know what to do if potential safeguarding concerns were raised. For example, records we saw showed there were incidents between people who lived at the service where pushing and shouting had occurred. This had been recorded but the service had not reported these incidents to Hampshire County Council under safeguarding protocols. They were also required to notify CQC without delay of any incident of abuse or allegation of abuse and they had not done so. Some action was subsequently taken to protect the person and others by increasing staff support and supervision and by consulting health care professionals. This meant the service had not put measures in place to keep people as safe as possible and increased the risk to people using the service of not receiving safe and effective care. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

At our last inspection in December 2015 we said medicines management was generally safe but some improvements were needed to ensure people received consistently safe care in this respect. The improvements related to the management of medicines identified at this time related to the storage of medicines, particularly the monitoring of temperature levels to ensure they were stored within an acceptable temperature range and in the administration of medicines, particularly guidance about 'as required' (PRN) and variable dose medicines.

At this inspection we found medicines were stored securely in a treatment room. The temperatures in the treatment room and for medicines stored in the fridge were monitored and were within an acceptable range.

There was written guidance about how staff should administer PRN (as required) medicines, for example, for pain relief when people were not able to tell staff if they were in pain. This helped to ensure staff were providing consistent care and medicines as prescribed to people who could not describe their physical conditions.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2015 we said some improvements were needed in staff training to ensure the service consistently provided effective care. We found at this inspection improvements were still needed.

Staff did not all have the skills and knowledge to carry out their roles and responsibilities. We asked staff what training they had. One night staff who had worked at the service since November 2016 who regularly led shifts said they had completed fire safety training and moving and handling training. A domestic staff who said they had worked at the service for about a year said they had only completed fire training. A senior staff who had been employed for six weeks said they had completed a very basic induction when they started. Although they regularly administered medicines, they had not completed medication training since starting at Stoneham House. They said they had completed training in the management of medicines at a previous job. This had been over two years previously. They confirmed they had had been observed administering medicines since starting at Stoneham house to check they were doing so safely.

There was a training matrix which showed staff had completed a range of health and safety training, although this did not correspond to the training staff described as having completed. There were large gaps in staff records regarding training competed which meant the service was not able to demonstrate when training had been completed and by whom.

One person living at the service had recently developed epilepsy and had at times behaviours which could challenge others. Staff were not provided with training in either of these areas to help them to support this person effectively. For example they were not able to describe the sort of seizures the person had and concerns had been raised by health care professionals who considered staff had not acted appropriately to support the person with this condition. Agency staff working at the service had completed more training via their agency than the regular staff. Profiles received by the service documented that agency staff had received training in safeguarding, first aid, medicines, moving and handling, health and safety, and behaviour which challenges. Staff said they did not receive formal supervision. Supervision is a formal opportunity for staff and their manager to meet and discuss their work, any issues or training needs and how to address these.

Staff were not supported or provided with appropriate training or supervision necessary to carry out their duties. This was a breach of Regulation 18(2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not very effective in the way they identified and managed nutritional risk. One person who was diabetic said they had to remind staff not to add sugar to their food. They said "I've had to ask them not to put sugar on my porridge, they seem to like doing that." We observed another person who was also diabetic eating sugar from a spoon. We alerted staff to this who then brought out a sweetener for this person instead. One person was assessed to be at high risk of dehydration. Staff had commenced a fluid chart to monitor their fluid intake. No target amount was listed on the chart and although amounts were totalled it was not

clear what the desired amount should be or what action was taken if the intake was low. Despite the person continuing to be at high risk of dehydration, fluid monitoring had been stopped in April 2017 with a note on the persons records to say "stopped fluid chart drank well." This was contravening advice given within the risk assessment where a person was identified as being at high risk of dehydration.

People liked the food. All people we spoke with said they had enough to eat and drink and said they enjoyed the variety of food provided. Representative comments were "They are very nice meals, always nice meals." "The food is excellent. For breakfast I can have anything I want. There's always a couple of choices at supper time and at dinner time." "They feed you very well. You get lots of choice." "I like home cooking, you get variety". A relative agreed saying "The menu is very good, varied and nutritionally balanced."

Staff understood the importance of asking for people's consent before care or support was provided. We observed staff giving people choices about, for example, where they wanted to eat, what they wanted to eat and where they wanted to spend their time.

Some people were unable to consent to aspects of their care and support. Where there was an indication that a person might not be able to make a decision about key or significant aspects of their care, there was evidence a mental capacity assessment had been completed and a best interests consultation documented. However not all of these had been completed appropriately in line with the Mental Capacity Act 2005. Staff said they needed more support and guidance about how to apply the principles of the Act and this was being provided by Hampshire County Council.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect the person from harm. The manager understood Deprivation of Liberty Safeguards (DoLS) had consulted with relatives and was in the process of making applications to the local authority responsible for making these decisions.

There was a clinic room so visiting healthcare professionals could see people in private if they did not wish to be seen in their bedrooms. Health care records were kept in the clinic room which enabled staff to monitor and update records about people s health care needs easily and in a timely way. The records were clear and effective.

The service liaised with healthcare professionals such as district nurses to support people with their healthcare needs. For example they worked cooperatively with district nurses to support one person who had a catheter. They contacted a GP for advice and support when a person had reduced their intake of food. There was clear guidance for staff to follow in the event of a person hitting their head, this included monitoring the person every hour to ensure their condition was not deteriorating. However we did not see any evidence that hourly monitoring had always been completed.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in December 2015 we said the service was caring.

People varied in their opinion about how caring the service was during this current inspection.. People generally said staff were kind and caring and we witnessed a lot of positive interactions with staff providing prompt care and support. People said of staff "I love them to bits." Another said "Everyone is so kind and nice. They are being so nice. I've got a very nice room." Another said "The staff are all nice and friendly, when they come in, we have a laugh." Some relatives were also positive about the service provided. One said for example (They are) "Very well cared for. My relative has been here four years and seems very happy." Another relative described how much they had appreciated being enabled to stay at the service for a few days to help their husband to settle in. Others were more ambivalent. One said "it (the service) has had a chequered history. There is need for improvement". Three had recently lost faith in the services ability to care for their relative consistently in ways which met their care and support needs and which protected their dignity.

Whilst people generally felt staff meant well there were a number of examples where staff did not always respect people's dignity. One relative raised a concern that whilst assisting their parent, staff could not find any wipes and were searching around for towels after helping them to the toilet. This was not very dignified. Other relatives and social care professionals had commented some people had long fingernails at times which were sometimes dirty. We observed one person walking around the service with holes in their socks. When we discussed this with staff they assisted the person to change them but the subsequent socks also had holes in them. We observed another person walking around with frayed trousers and poorly fitting shoes. Staff said the person concerned was very independent and did not like staff to interfere with their dressing. The person's plan of care however gave clear guidance about how staff could assist this person to have fresh clothes. Their care plan also said they preferred male carers but this had not been considered as a strategy to assist the person. At a subsequent visit the person had different clothes on and different shoes, but the shoes lacked laces.

Sometimes the service was slow to take action to relieve people's discomfort. When we visited the service on 22 May 2017 the temperature in the cool part of the lounge was 28 degrees. There were small fans positioned in the room but they did not have any effect upon the temperature. One resident was sitting in the hotter part of the lounge. They were noticeably hot and asked to move. Staff assisted them to a cooler part of the room at our request. Staff said of the heat "It gets very hot in here. It is 29 degrees at the moment. It is like we are sandwiched between two greenhouses. I have said about it before, but I'm not sure what can be done." Another said "It's always too hot in here, it's not even summer yet." We discussed our concerns about the excessive heat with the provider. On 25 May 2017 when we returned for a further visit the provider had purchased an air conditioning unit which was placed in the lounge which had reduced the temperature to a more reasonable level. We were concerned that the service would not have taken action to relieve people's discomfort if we had not raised this with them.

Although bedrooms appeared clean and tidy we noticed a malodour in four bedrooms and there was also a

malodour in the main lounge. Staff said the carpets were cleaned regularly but this did not make a significant difference to the odour. They said the carpets needed to be replaced. This was discussed with the provider who voiced concerns about the financial commitment this would entail. Relatives were told at a meeting in May 2017 that plans for the refurbishment of the home as laid out by the previous registered manager would have to be delayed due to loss of finances.

This was a breach of Regulation 10 of the Health and Social care Act (Regulated Activities) Regulations 2014 as service users must be treated with dignity and respect.

There was a relative committee which encouraged families to become involved in their relatives care and in the day to day activities of the home. There were occasional relative and residents meetings when people would be updated regarding significant events and invited to participate, for example they were invited to take part in fund raising events and to attend planned social events.

People's privacy was respected. There were different communal areas people could use when they had visitors so they could have conversations in private if this was their wish. Meals could be taken in resident's rooms or in the dining or living room. Visitors were invited to eat with their relatives.

Inadequate

Is the service responsive?

Our findings

We asked people how much they were supported with their care needs. Delays in responding to call bells were an important issue for residents. One person said for example "They don't always come quickly. It depends on what they are doing, they have a lot of work getting people up.'' Another said "I ring the buzzer and wait and wait. I've waited up to 20-30 minutes. I can get on the toilet, but I can't get off."

Care was not centred on people's needs. There was a bathing rota in the office. The fact people were allocated a particular day for a bath indicated to us the service was not delivering person centred care which was responsive to people's needs and wishes. One person was due to be offered a bath every Saturday. Their care plan said they liked a bath on Wednesday and Saturdays. The person concerned was doubly incontinent. Records we checked said they received a body wash every day but had only had a bath once in the past two months. Other records we checked indicated other people were provided with very few baths. Staff said they were sure people had been provided with more baths than their records reflected, but had to think when asked when they had last assisted a person in their care to have a bath. One staff said "It is more to do with staff not having time rather than people's preference."

Care plans provided a variable quality of information to guide staff about how to provide individual care to meet people's specific needs. A relative said the care plan in their parent's bedroom was out of date and some bits were inaccurate. Staff said that this was not the most current care plan which was stored on the computer. The relative was concerned that new staff who did not know their parent would read incorrect information and therefore not provide appropriate care. They said "The care plan is meant to guide staff. How are they going to know what to do if the right care plan is not even in the room?"

We found some care plans had not always been updated to reflect peoples changing health and care needs. One person had developed a specific health care need which had not been reflected in their care plan. This meant staff did not have clear written instructions about how to care for this person in response to their needs and increased the risk of them receiving inappropriate care and support. Staff were sometimes slow to respond to people's changing health care needs. One visitor told us their relative who was hard of hearing had lost their hearing aid the month before. They were still without one which made communication much more difficult for them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not providing person centred care.

Complaints and concerns were not used as an opportunity for learning or improvement. We were made aware of some concerns from relatives which had not been recorded in the complaints log, The complaints made, if substantiated, could have had a significant impact upon the wellbeing of people living at the service. For example one relative told us said they officially complained about the treatment of their mother but there was no record of this. As complaints were not recorded it was not possible to track what action, if any, had been taken to investigate and where necessary to take action to reduce the risk of adverse events reoccurring.
This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

There were some elements of good practice. Some people had a 'This is me' assessment in their records. This is me is a tool for people living with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes. This can be transferred with people if they need to go into hospital to help health care professionals understand what is important to people. This would help to guide health and social care staff to provide appropriate care for people which is in line with their needs and wishes when they transfer between services.

Hampshire County Council who commission care for many of the people living at Stoneham House had completed reviews of care of all people living at the service. They were working with the service to help to improve people's experience of care.

An improvement since the last inspection was that the service had employed a full time activity coordinator. The activity coordinator organised group activities which people were encouraged to participate in. They also provided one to one support for people who did not enjoy group activities. For example, they spent time doing a crossword with one person and then reminiscing with another and painting the nails of another person. There was a new activities room where people could do individual artwork or puzzles or word searches if that was their wish.

Some people at the service were living with dementia or had other cognitive impairments. Largely the environment was not adapted to help them to orient themselves around the home, however some work had started to make the environment easier for people to identify their bedrooms and toilets. For example, some people had their bedroom doors personalised to reflect things that mattered to them which would help them to identify their own bedroom from those of other people.

Inadequate

Is the service well-led?

Our findings

At our last inspection in December 2015 we said the service needed to improve in order to demonstrate they encouraged and delivered an open, fair and supporting culture. A new manager was in post who had started to make positive changes to the service although the full impact of these changes had yet to be experienced by people who lived at Stoneham House. We were assured at that time the new manager who we subsequently registered, had clear plans in place to effect the changes needed.

In the middle of this current inspection the registered manager left and an acting manager who intended to apply for registration with the Care Quality Commission took over the management of the home. It became clear during the course of the inspection that the culture of the service was not always open and positive. Examples of this were that we received whistleblowing concerns from staff and some complaints from three relatives who had not felt their concerns had been sufficiently listened to. As a result, despite occasional relatives and residents meetings some relatives said they had lost faith in the service, particularly in the provider. Staff described a culture where communication was not always open. This meant when things went wrong they were not always investigated quickly. Staff did not always report these issues to outside agencies such as Hampshire County Council who were commissioners of the service for most people living there and who were responsible under safeguarding to take the lead in investigating alleged abuse. The provider and their family had taken over aspects of the management of the service, for example the accounts. At the time of our inspection visits in May 2017 the accounts were completed by a member of the provider's family and another staff member who has subsequently become the finance manager. Following our visits the finance manager said they had enrolled on a diploma course in HR and accounts. However, at the time of our inspection visits staff lacked the skills and experience to answer our questions about the finances of the home. At the time of publication we still have not received all of the information about the services financial position that we have requested. As a result there were insufficient external checks to ensure the service had done all it could to keep people safe and to manage the business effectively.

The acting manager demonstrated a clear commitment to providing as good a service as possible and was approachable and willing. They acknowledged they had some gaps in their skills and knowledge. They were unable to delegate management tasks to senior staff such as staff supervision and quality assurance audits as they did not have sufficient senior staff in post who had been trained to do this. They were assisted by the provider's family who were responsible for maintenance and accounts but they too lacked sufficient training and experience to undertake many of these tasks effectively. Not all staff had job descriptions which meant their main duties and responsibilities were not clear, for example it was not clear who was responsible for pre-employment checks for new staff. The lack of clarity resulted in shortfalls in service provision with few regular audits and little analysis of how to reduce risk when adverse events occurred.

Quality assurance processes were not robust which meant staff were not always aware of potential risks which could compromise quality. We identified a number of areas where people had been put at unnecessary risk. These included staff not following agreed protocols to protect adults in their care for example, an inconsistent approach to mitigate risk to individuals or to manage risks within the

environment.. This was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good Governance.

It is a legal requirement that the service notify The Care Quality Commission without delay of significant incidents which may affect the safety and wellbeing of people using the service. This had not always been done when necessary.
This was a breach of Regulation 18 The Care Quality Commission (Registration) Regulations 2009.

Support had been offered from Hampshire County Council to assist the acting manager to improve the service but this was yet to start. In the meantime the acting manager had no effective support or supervision to assist her in her role. The provider took some interest in things that happened in the service but lacked skills and experience to effect the change needed in a timely way. This was evidenced by the fact the service had previously been rated as inadequate in June 2015 and the provider had not taken action to improve until this rating had been given.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service is required to notify the Care Quality commission without delay of significant incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service was not providing person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users must be treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person must assess the risk to the health and safety of service users receiving care and do all that is reasonably practical to mitigate any such risk.

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

The service had not put measures in place to keep people as safe as possible and increased the risk to people using the service of not receiving safe and effective care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not act upon complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure good governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures must be established and operated effectively to ensure suitable staff are employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient and suitable people deployed to cover both the emergency and the routine work of the service.