Stanley House Limited

Stanley House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection carried out on the 09 May 2018, with a further announced visit on the 17 May 2018.

Stanley House is a 'care home'. People in care homes received accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Stanley House accommodates up to 21 people within one adapted building. It specialises in supporting people who have either Huntington's Disease, acquired brain injury or people with mental health needs who also have physical disabilities. At the time of the inspection there were 18 people living at Stanley House.

There was a registered manager in post at the time of the inspection, who had been in place since December 2016. 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 our last comprehensive inspection of the service in June 2016, the overall rating for the service was judged to be 'good.' At this inspection we have rated the service as 'requires improvement'.

During this inspection we identified three breaches of regulation. These were in relation to safeguarding people from abuse or improper treatment; concerns about good governance; and failure to notify the CQC of incidents involving alleged harm or abuse.

Allegations of abuse or harm had not been investigated effectively or appropriately. Allegations of abuse or harm had not been shared by the provider with the local authority, or with the Care Quality Commission. This meant people were not always protected from potential abuse. The management team did not demonstrate an understanding of their role and responsibilities in terms of investigating and reporting allegations of abuse and harm.

Registered providers are required by law to notify the CQC of incidents where people have suffered harm, injury, abuse or suspected abuse. The provider failed to notify CQC of two allegations of abuse that had occurred in December 2017, and February 2018. The provider had also failed to notify us of one serious injury notification in November 2017.

We found management systems were not always effective. We found the provider lacked a clear strategy in relation to the effective monitoring of the quality of services provided by staff. This was demonstrated by the failure of the provider to identify allegations of abuse, and to ensure that action taken to investigate and ensure people were safe. Though the provider had some management systems in place to record and monitor the standards of care delivered within the home, these were not always completed or were

effective.

Care plans and risk assessments were not always accurate and contemporaneous, and did not always reflect people's current care needs. We found that staff supervision had not been consistently undertaken.

The use of bed rails can act as potential restraint. Where people lacked mental capacity to consent to their use, there was no consistent evidence of best-interests decision-making.

We identified concerns regarding pressure area prevention and management. This related to the use of appropriate equipment and the lack of referral to other health care professionals. Risk assessments regarding pressures sore management, were not being consistently reviewed.

Relatives and visiting health professionals consistently told us they believed people were safe living at Stanley House.

The registered manager showed insight into the Accessible Information Standard, and we saw people's communication needs had been assessed and recorded.

Relatives and health care professionals were satisfied with the overall competence and knowledge of the nurses and care staff.

Staff adopted a kind and compassionate approach towards the people they supported.

Management promoted an inclusive culture, which encouraged people, their relatives, and staff to speak their minds at any time. The culture of the home was open and transparent.

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?

Requires Improvement

The service was not always safe.

The provider failed to mitigate and manage risk effectively.

People were not always protected from abuse and improper treatment. Incidents of abuse had not always been reported or action taken to ensure people were safe.

On the whole, people received their medicines safely and medicines were stored securely.

There were sufficient staff to meet people's needs and keep them safe.

The home used safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have an appropriate understanding of, and fully promoted, people's rights under the MCA.

Staff confirmed they received regular training, but formal supervision had been inconsistent.

Staff supported people to access healthcare services to ensure their health was regularly monitored.

People's dietary requirements were assessed and appropriate care plans and risk assessment were in place.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive care that was kind and compassionate, and received the emotional support they required.

Staff demonstrated a good understanding into people's personalities and individual needs.

People were involved in planning and reviewing their care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always up to date and accurately reflected people's current needs.

People enjoyed social and leisure opportunities within the home and in the local community.

People's relatives knew how to raise concerns with the provider.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to make statutory notifications to CQC.

The provider's monitoring of people's care needs was still not always effective in identifying and acting on shortfalls. Records associated with people's care were not always accurate, up-to-date or completed.

The culture of the home was open and transparent. Staff felt valued and were confident that they would be listened to if they raised any concerns.

Stanley 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 inspection was prompted in part by notification of an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk in the service. Whilst we did not look at the circumstances of the specific incident, which may be subject to a criminal investigation, as part of this inspection we looked at associated risks.

This was an unannounced comprehensive inspection carried out on the 9 May 2018, with a further announced visit on the 17 May 2018. The inspection was carried out by two inspectors, and a specialist advisor in nursing. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection.

The inspection visit was undertaken before the provider had been able to complete a Provider Information Return, however this was provided to us during the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We also contacted the local authority and their safeguarding team, Herefordshire Clinical Commissioning Group and Healthwatch for any information they had, which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with two

people who used the service and four relatives. A number of people at the home were living with medical conditions that meant they were unable to speak with us. We spent time observing interaction between staff and people who used the service. We also spoke to eight health professionals, and an Anglican priest, who provided us with information regarding their engagement with the home.

We reviewed a range of records about people's care and how the home was managed. We looked at nine care records, medicine administration records, five personnel files and records relating to the management of the service.

As part of the inspection, we spoke with the registered manager, regional manager, the deputy manager, two nurses, two senior care assistants, four care assistants, cook, administrator, maintenance person, and two domestic cleaners.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection in June 2016 the 'Safe' key question was rated as 'Good.' At this inspection we found improvements were required.

The inspection was prompted in part by notification of an incident, which had resulted in a person sustaining a serious injury from scalding whilst being bathed. We looked at what action the provider had taken to ensure people were safe when receiving a bath.

We were shown the bath, which had been the subject of the scalding incident. The maintenance person explained and demonstrated that an independent thermostat control had since been installed with a set temperature of 39 degrees centigrade. This control could not be overridden by people or staff using the facility. A similar system of temperature control existed for the other bath that was available at the home.

We saw, and staff confirmed, that clear instructions from the provider were available, which outlined the responsibility of staff members to ensure they tested the temperature of the bath water before each use. The written instructions stated staff were required to check with a thermometer and their elbow before bathing a person, with a maximum temperature of 44 degrees centigrade.

The registered manager told us that since the incident, a daily system of 'bath audits' were being undertaken by senior care staff. This was to ensure temperature records were completed consistently and that temperatures were safe.

We spoke to staff about the availability of thermometers, who confirmed that sufficient thermometers were available at the home, to ensure temperatures were checked and were safe. If a thermometer was not available in the bathroom in question, others were available in the second bathroom of in the nurses' office. One member of staff told us, "The policy is clear, bath temperatures must be checked. I've always been told that since I've been here, 'you must.' You must use a thermometer."

We found the provider did always not have effective systems and processes to safeguard people, immediately on becoming aware of, any allegation of abuse. A recent allegation of abuse, regarding an alleged assault had not been reported to the local authority safeguarding team in line with locally agreed procedures. The registered manager confirmed that no internal investigation had been carried out, and no further action had been taken. They also confirmed they had not notified the local authority or the Care Quality Commission (CQC) about this incident. A further allegation of neglect had also not been reported in line with local procedures and the requirements of regulations to CQC. This meant people were not always protected from potential abuse. Providers must make sure they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding incidents must also have the right level of scrutiny and oversight by the local authority and CQC.

The registered manager told us they recognised that in the past, safeguarding training has not been as robust as it should be, and that they had not felt confident with the application of safeguarding procedures.

As a result, they had already trained two staff to deliver 'face to face' training, which would be cascaded to the staff team. The registered manager also confirmed they had just completed advance training in safeguarding for managers. They felt this had provided greater awareness safeguarding incidents and confidence in reporting them in the future.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), safeguarding people from abuse and improper treatment.

We looked at how the home managed people's medicines, and found that on the whole, arrangements were safe. People received their medicines in line with their prescriptions. When people were prescribed medicines to be taken 'when required' (PRN), information was not always available in medication administration records to help staff decide when the medicines were needed. This meant people were at risk of not being given medicines when they needed them, or too often. Pain scoring tools were not always available to help staff determine whether people who could not communicate, were experiencing pain. This would be particularly relevant for agency nurses, who would not know the person they were supporting.

The service mainly used a 'blister pack' system for people to store their medication. 'Blister pack' is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the service. The pack has a peel off plastic lid and lists the contents and the time the medication should be administered. We found all medicines were stored securely. Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were stored as per legislation. They were stored in a locked storage unit. We undertook a stock take of controlled drugs and found them to be correct. However, we found controlled drug medicines for two people who has passed away eight weeks earlier, had still not been disposed of. Medication should be destroyed at the earliest opportunity if no longer required, as per the provider's medicines policy.

People had individual assessments of risk associated with their personal needs in place and these included bed rails, falls, pressure sores, restrictions of physical mobility, and moving and positioning. However, risk assessments and associated pressure sore management, were not being consistently reviewed. In addition we identified concerns, on occasions, related to the failure to risk assess for the need to use pressure relieving pneumatic air mattresses in order to reduce the risk of pressure sore development. The clinical lead told us that "most of our residents can wriggle when uncomfortable." However, this cannot be guaranteed and assessments into the risks associated with this had not always been undertaken.

One person who had a pressure sore had not been referred to the Tissue Viability Nursing team, which meant they could be at increased risk of the wound deteriorating further, without specialist advice. We discussed this with the clinical lead and a referral was made on the day of our inspection.

We looked at moving and handling equipment, such as hoists and standing aids. Slings were individual and equipment was clean and regularly inspected.

Relatives and visiting health professionals consistently told us they believed people were safe living at Stanley House. One relative told us, "I think it is fantastic. I do feel my relative is safe here and gets good care. I have been present when staff support my relative. They meet their needs and are safe when using equipment." Another relative said, "They [relative] is safe and we have confidence in the care they receive." One health care professional told us staff were able identify medical and psychiatric needs of people and were aware how to appropriately triage these. For example, arranging for an emergency response where appropriate or referring to the GP or the local mental health crisis team. They explained that some people at the home were living with Huntington's disease and had complex psychiatric presentations, which staff

managed well. They also said that though they were aware of the recent scalding incident, it did not reflect, in their experience, the overall standard of care at the home. Another visiting health care professional told us staff were very caring with a deep knowledge of the people they cared for, and the support staff provided was generally above and beyond what would be expected of them. They were aware of the recent incident, but in their experience described it as an isolated event, as they could not recollect any other significant events.

People, their relatives and staff felt the staffing levels maintained at the home meant people's individual needs could be met safely. One relative said, "Enough staff here. I often visit and there are never any moans of staff shortages." Staff had time to engage, sit and chat with people during our visit. Staff told us there were sufficient numbers of staff on duty to enable them to care for people and in the event of sickness or other absences, agency staff were employed to cover any shortfalls. One member of staff told us, "Best staffed place I have worked at. Sufficient staff to meet people's needs, and plenty of peer group support here."

Staff told us and we saw that the provider followed safe recruitment processes. We saw Disclosure and Barring Service (DBS) and references were completed for new staff prior to starting work with people. A background check called a DBS check is a legal requirement and is a criminal records check on a potential employee's background. The provider also undertook three yearly DBS checks on staff to ensure they remained safe to work with people who lived at the home.

The areas of the home we visited were clean and smelt fresh. Health professionals told us they found the home clean and welcoming. There was good provision of personal protective equipment (PPE), such as gloves and aprons and hand washing facilities to enable staff to comply with good hand hygiene practice. The registered manager explained cleaning schedules were in place for staff. Cleaning staff confirmed they had received training in infection control and prevention and received weekly deliveries of cleaning materials.

Requires Improvement

Is the service effective?

Our findings

At the time of our last inspection in June 2016 the 'Effective' key question was rated as 'Good.' At this inspection we found improvements were required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where DoLS authorisations had been granted, the registered manager was aware of the need to review any associated conditions, in order to comply with these.

One health care professional told us a number of people with Huntington's disease lacked mental capacity at Stanley House. They described staff as appearing to understand the Mental Capacity Act, who knew how to assess capacity, and had a sophisticated understanding of how to act in a person's best interests. They said staff were careful to follow the procedures laid out in the act and frequently sought advice from professionals and arranged best interest meetings where appropriate.

However, we were not always assured all staff had an appropriate understanding of, and consistently promoted, people's rights under the MCA. For example, we found that before using bed rails, which can act as potential restraints, where people lacked mental capacity to make this decision, there was no consistent evidence of appropriate best-interests decision-making. We spoke to the registered manager who agreed that best interest decisions were not always in place regarding bed rails. They explained that bed rails have been discussed and agreed with families or authorised people in the past, but acknowledged there was a need to undertake formal best interest meetings about certain aspects of people's care and treatment, including bedrails.

Throughout our visit we observed staff sought consent from people before undertaking any routine tasks. They also explained to people what they wanted to do, such as how they would support people mobilising and why.

Relatives and health care professionals we spoke with were satisfied with the overall competence and knowledge of the nurses and care staff. They felt that staff had the necessary skills and knowledge to meet people's needs. One relative told us, "I have had the opportunity to get to know the staff well. I'm impressed how well-trained staff are." Staff spoke favourably about the training and support they received and felt valued by the provider. However, some staff told us formal on-going supervision was inconsistent. Staff should receive appropriate on-going or periodic supervision in their role to make sure competence is maintained. One member of staff told us they had not received supervision since their appointment in March 2017. Another member of staff told us they had not have any formal supervision since the new

provider took over in the summer 2017. The management team acknowledged this was an area of improvement and told us a system of formal supervisions had recently been implemented.

Staff told us they had undertaken an induction programme when they had first started, which included training and a period of 'shadowing' (working alongside more experienced staff members) before being able to work unsupervised. Following the induction process, staff attended mandatory training and completed e-learning (on-line) training. Other training included NAPPI (Non-abusive and psychological intervention) principles to enable staff to manage any behaviours that challenge in the least restrictive way. Nurses were offered opportunities to undertake additional training, such as a catheterisation or percutaneous endoscopic gastrostomy feeding (PEG) courses to develop their own skills. The registered manager told us the provider was pro-active in encouraging personal development and has their own academy for newly qualified nurses. Care staff were also encouraged to undertake nationally recognised qualifications in social care.

Risks associated with people's eating and drinking were assessed, with appropriate input from health professionals such as GP and the speech and language therapy (SaLT) team. We saw that staff recorded people's food and fluid intake. Totals and running totals were maintained of fluid and food intake, which was regularly reviewed by nursing staff who highlighted any deficits. We observed that by 3pm on the first day of our inspection, a number of people appeared to have consumed low levels of fluids. This was identified by nursing staff who then together with care staff proceeded to resolve any imbalance by encouraging people to drink more.

People were provided with a choice of meals. One person told us, "We have different meals and we get asked every day what we want for dinner and tea. We are offered a choice." We saw staff supporting people at meal times to eat, with patience and respect. We spoke to the head cook, who told us that they followed a menu, which had just been changed from a winter to a summer menu. They told us they spoke to people to determine their preferences, and provided meals in various forms to meet specific needs, such as pureed, soft, mashed and diabetic. They confirmed that people were asked on a daily basis what they wanted and alternatives to the menu were always available.

Corridors and communal areas were spacious and light, and people freely chose where they spent their time. People were supported to access the enclosed inner garden area and the main external gardens, which were extensive. We saw people spending time with relatives and staff in these external areas, where the atmosphere was relaxed and calm.

We asked people about how they were supported to access external health services. People and relatives confirmed health care professionals, such as the local GP, physiotherapists and specialists in neurophysiotherapy were in attendance at the home on a daily basis. The provider confirmed they worked closely with the local CCG and with the Huntington's Disease Association. They also had close links with the local hospice and community MacMillan team, who provided training as well as support for both people and staff. One health care professional told us staff were very caring and always raised concerns as soon as they arose. Another health professional described management and senior nursing staff as being passionate about giving good care to people with Huntington's disease and sought innovative solutions to problems where needed.

Requires Improvement

Is the service caring?

Our findings

At the time of our last inspection in June 2016 the 'Caring' key question was rated as 'Good.' At this inspection we found improvements were required.

In relation to the two safeguarding incidents, these had not been reported to the local authority in line with locally agreed procedures and as an independent oversight. Management at the home acknowledged a lack of training and confidence in managing safeguarding incidents prior to these incidents. During the inspection we asked the provider to take immediate action to address these concerns, who subsequently notified us of the two incidents involving allegations of abuse. One of these matters related to an allegation of assault against an unknown member of staff. These matters had not been investigated by the provider at the time. We could therefore not be certain that the person involved in the altercation had received care that was kind, respectful and compassionate, and had received the emotional support they required.

People, their relatives, visitors and health professionals consistently told us staff adopted a kind and compassionate approach towards the people they supported. One person said, "I love it here. Plenty of staff who always listen to me." One relative told us, "All the staff have a wonderful relationship with my relative. I believe staff are very kind and respectful, it can be quite challenging at times." Another relative said, "Much better than anywhere else they have stayed. Management listen and act. We have complete confidence in what they do and what they have achieved for our relative." A third relative told us, "I think they are safe and cared for appropriately. This is the third place my relative has been at and there have been great improvements. They are settled and less anxious."

One regular visitor to the home, an Anglican priest told us, "I have always been deeply impressed by the sense of community at Stanley House, by the friendships that exist between residents, by the skill and sensitivity of the staff and by the affirming relationships that clearly exist between the residents and the staff. The holistic approach towards each resident's needs is evident. Each person's spiritual needs are respected and clearly of high priority." A health care professional told us they considered the care the staff provided to people was exceptional. Another heath professional said they always felt the staff (including domestic, catering, and maintenance personnel) knew people who lived at the home very well, and had built a really good rapport. They told us staff were kind, patient and very caring, and genuinely cared about the well-being of the people they supported. A third health professional described staff as being caring and prepared to "go the extra mile," in support people's needs.

People looked well-cared for, clean and comfortably dressed and were supported by staff in a way that was kind, respectful and compassionate. Throughout our visit, we saw staff engaging with people in a caring manner. Staff demonstrated a good understanding into people's personalities and individual needs. We saw staff responded promptly in the event people became distressed or needed emotional support. The atmosphere was calm and relaxed throughout. People were clearly at ease with staff who supported them.

People and their relatives confirmed they were involved in care planning and were always consulted if there were changes required. One relative told us, "I do feel involved in my relative's care and they keep me

informed. They have told me about recent changes in their medication. They do listen and contact health professionals on my behalf." Another relative said, "I feel they listen and respect our wishes and we have had meetings." A third relative told us, "They do listen and take account of my views and always respond positively."

Staff confirmed that they encouraged people to be independent as much as they could to improve confidence and well-being. One member of staff told us how they encouraged one person to be independent, otherwise they became too dependent on staff, but was more than capable of doing things themselves. The outcome was that the person enjoyed helping out, which made them feel valued and wanted. Another member of staff said, "We encourage independence to promote a better quality of life, so I encourage people to do as much as they can."

Requires Improvement

Is the service responsive?

Our findings

At the time of our last inspection in June 2016 the 'Responsive' key question was rated as 'Good.' At this inspection we found improvements were required.

Care plans were not always up to date and contained inaccurate information. For example, we saw risk assessments and care plans in place for the treatment of a male person, who had been referred to as 'she' and 'her.' One relative we spoke with highlighted the fact that their loved one's care plan had contained incorrect information, which in fact related to another person residing at the home. When we reviewed the care plan, the incorrect information had been scored out. The care plan had not been updated. The registered manager confirmed that the incorrect information related to another person.

We found reviews and evaluation of care were inconsistent. These were set to take place every six months, however a number of people had highly complex needs, which changed on a frequent basis. We could not be assured that setting a six month review would capture people's changing needs effectively.

Where six monthly review and evaluation dates had been set, we found a number of examples where these had not taken place. In one example, the reviews had been set for the 28 January 2018, but these had taken place. The last recorded review for this person had taken place on the 19 September 2017. 'Vital signs' are checks normally undertaken for general nursing care residents, either monthly or less, dependent upon the person's individual needs. We identified that the frequency of recording these had reduced significantly. In one example we looked at there was an unexplained a gap of 4 months, where checks had not been undertaken. We spoke to the new clinical lead about these matters, who told us, things had slipped since the last clinical lead had left the home in December 2017. This meant we could not be assured that care plans accurately reflected people's current needs.

The registered manager was aware of people's protected characteristics under the Equality Act 2010. They assured us people's related needs, including their spiritual beliefs, were considered as part of the assessment and care planning processes. Equality Diversity and Human Rights EDHR) were discussed at staff meetings and mandatory training was provided. Staff had been involved in ensuring cultural and religious needs were met, which included diet, prayer and religious procedures around death. The registered manager told us they always ensured any issues were discussed openly and transparently, and staff supported people with their own personal thoughts and views. They emphasised they would always respect individual's personal wishes and would only share information if they wanted it.

The registered manager showed insight into the Accessible Information Standard, and we saw people's communication needs had been assessed and recorded. This standard requires publically-funded bodies to provide key information about people's care in a variety of formats for people who have sensory impairments. The registered manager told us the provider was able to print any information a person required in larger print as necessary, and staff were able to spend time reading to the individual. Where necessary, picture boards were used to assist communication. Several people at the home were supported with electronic communication aids to facilitate communication.

Throughout our visit we saw people were being stimulated individually and in group activities with therapists. A weekly activities schedule was in place for people, which included art therapy, sensory relaxation sessions and trips off site to a hydro therapy pool. One relative said, "[Name] goes on trips, when they are calm enough and within their limitations. They are involved in activities, which they watch and enjoy." The art therapist told us, the sessions were varied, which included a range of materials, such as sensory, exploratory, personal, humorous, and seasonal. This provided people the opportunity to keep in contact with family and friends. They also said the sessions were entirely inclusive and all people at the home, which reflected the ethos of person centred care at Stanley House. People were also involved in community events such as an annual Poetry Festival, where artwork made at the home was displayed. Postcards made at the home were sold at a local gallery to raise money for a children's charity.

At the time of our inspection visits, no one at the home was receiving palliative care. We looked at two 'end of life,' care plans, which contained relevant information regarding people's wishes and preferences and involved families and professionals. However, some information was unclear and potentially confusing. For example, one comment stated "no heroic action." Information should be concise and clinically acceptable, which reflected people's requests. The registered manager told us the local authority was currently introducing an end of life care pathway, alongside training packages for care homes. Stanley House intended to become part of this network to ensure they retained the Gold Standards framework for end of life care. Staff confirmed they had received training in this area, and felt confident in meeting people's needs.

People and their relatives knew how to raise any concerns and complaints about care at the home. They felt comfortable to raise any concerns or complaints with staff or the registered manager. The registered manager told us all complaints or concerns were fully investigated and opportunities to improve practice were identified.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection in June 2016 the 'Well-led' key question was rated as 'Good.' At this inspection we found improvements were required.

Registered providers are required by law to notify the CQC of incidents where people have suffered harm, injury, abuse or suspected abuse. The provider failed to notify CQC of two allegations of abuse that had occurred in December 2017, and February 2018. The provider had also failed to notify us of one serious injury notification in November 2017, relating to an event regarding a person's health condition. The registered manager acknowledged they had been unaware of their responsibilities in respect of the regulatory requirements the under Care Quality Commission (Registration) Regulations. Following our inspection visit, the registered manager ensured all statutory notifications were made to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2014.

We found management systems were not always effective. We found the provider lacked any clear strategy in relation to the effective monitoring of the quality of services provided by staff. This was demonstrated by the failure of the provider to identify allegations of abuse, and to ensure that such matters were recorded accurately and action taken to ensure people were safe. Furthermore, the management team did not demonstrate an understanding of their role and responsibilities in terms of investigating and reporting allegations of abuse and harm. This did not assure us they were aware of key legislation underpinning their daily practice.

Although the provider had some management systems in place to record and monitor the standards of care delivered within the home, these were not always completed or were effective. For example, daily audit checks of medicines were taking place by staff, regarding tablet counts. However, these were ineffective as we found gaps in the counting process. The deputy manager told us that management auditing of medicines had only commenced since the 8 May this year. Prior to this, they told us a daily, informal daily information sharing system had been used. However, they confirmed this system had been used to communicate missed signatures on MARS, and had not looked at areas such as PRN protocols, medication being left out and stock management. Fridge and room temperatures had also not been consistently recorded. There was an ineffective system of governance in place to identify and address these issues.

Care plans and risk assessments were not always accurate and contemporaneous, and did not always reflect people's current care needs. Where review and evaluation dates had been scheduled, these had not always been undertaken to reflect people's current needs. There was no system in place to review and ensure care files were accurate and up to date, reflecting people's current needs. This meant the provider was not following their own policies and procedures in regard to care plan reviews.

When we looked at accident and incident forms, we found these did not contain any information as to what action had been taken. For example, one person had fallen out of their wheelchair and hurt their back. The form stated the cause of the problem was an "inadequate" wheelchair. There was nothing recorded as to

action taken about the wheelchair, or what the nature of the back injury was. It was not possible to ascertain from the accident and incident forms whether the provider had done all that was reasonably practicable to mitigate risks associated with people's care and support needs, and whether information was used to update people's individual risk assessments. We found other examples of accident and incident forms where injuries had been sustained by people, but the detail was lacking in the records. For example, one person had sustained an injury to their mouth, but it was unclear what the extent of the injury was, what treatment had been offered, and what had been done to prevent a reoccurrence. The management team did not have this information readily available when asked. There was no evidence to suggest incidents were used as a 'lessons learnt' and shared with the staff team We spoke with the management team about this issue, who told us a more effective monitoring system would be introduced.

We found staff supervision had not been consistently undertaken since the new provider had taken over the home in the summer of 2017. Both the registered and deputy managers spoke of the challenges they faced since the change of provider. They told us they have been waiting for the provider's audit tools for the last 10 months, but these had been inconsistent. They told us this delay had meant certain key areas affecting the running of the home had not been routinely monitored and audited, such as infection control. Where audit tools have been provided, they said these were not fit for purpose as they were intended for mental health services and not applicable to neurological nursing homes like Stanley House. The described the current governance as being "a bit all over the place", with some new systems being used as well as some of the old ones. Additionally, due to the absence of a clinical lead since last December 2017, the deputy manager was covering the clinical lead and had been unable to support registered manager effectively. Things had improved recently with the new appointment of a clinical lead.

This was a Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider had failed to effectively assess, monitor and improve the quality and safety of services provided and ensure records were up to date and accurate.

Meetings involving people who lived at the home had taken place, where feedback had been sought and acted upon. For example, people had asked for a trip to a local theatre, which had been arranged. People had also asked for more additions to the menu, which had also been addressed by the home. However, the registered manager could not demonstrate other ways in which people's feedback was sought. For example copies of the most recent service satisfaction questionnaires completed by people, relatives and health professionals were not provided. The provider told us plans were in place to distribute further service satisfaction questionnaires shortly.

The maintenance person provided evidence to demonstrate regular fire safety checks of systems and equipment, electrical testing of electrical appliances, water temperature / legionella, maintenance and health and safety checks.

People and staff told us they were happy with the management of the home, who promoted an inclusive culture, which encouraged people, their relatives, and staff to speak their minds at any time. The culture of the home was open and transparent. Staff felt valued and were confident that they would be listened to if they raised any concerns with management about the service. Staff were aware of the provider's whistleblowing policy and told us they would follow this. One health care professional told us communication was good and that management was supportive and approachable. They felt people were treated with dignity and respect. They had not been made aware of any concerns from staff, people or relatives regarding the management of the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did always not have effective systems and processes to safeguard people, immediately on becoming aware of, any allegation of abuse.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of services provided and ensure records were up to date and accurate.

The enforcement action we took:

The provider and registered manager were served with a warning notice, which required compliance with Regulation 17 by the 1 August 2018.