Mrs Audrey Robinson

Stanbeck Residential Care Home

Inspection report

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Workington
Cumbria
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Tel: 01900603611

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 May 2016. The inspection was unannounced.

Stanbeck care home is situated in a residential area on the outskirts of Workington.

Accommodation is provided over two floors with a variety of communal lounges, dining room, patio and garden. All bedrooms are for single occupancy and have en-suite toilet facilities.

The service is registered for 13 people. On the day of our inspection there were 12 people living at Stanbeck.

At our last inspection of this service on 28 June 2013 we asked the provider to make improvements to the care planning and risk assessment processes that were in place at the home. This action had not been completed.

We also asked the provider to make improvements to make sure medications were administered safely. The registered provider had sent us an action plan detailing how and by when these improvements would be made but adequate actions had not been taken.

There is a registered manager at the home. 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.

All of the people who used this service, who we spoke to during our inspection, told us that the staff were "very nice" and most said they were "treated kindly." We did not receive any complaints about the service although one person did say that the staff could sometimes be "brusque." However, they did not want to give us any further details about this.

A visitor to the home told us; "There seems to be plenty of things for people to do here. It is a small home and I think the people who live here get more attention."

Care workers told us that they had; "Time to give care because it is a small home" and people who used the service all said that the staff "usually" attended to them "very quickly." We saw that staff were respectful of people's privacy and dignity and only intervened when necessary or when people requested their help.

On the day of our inspection the home was generally clean, tidy and there were no unpleasant odours. One of the people who used this service particularly commented on the good standard of cleanliness of their room.

The registered provider had safeguarding procedures in place but these were unclear, inaccurate and

needed to be reviewed. More than half of the staff at the home had not received training to help them identify and effectively report abuse allegations.

In the sample of care records we looked at we found that people's care plans and risk assessments were out of date and did not reflect their current support needs and preferences. There were inconsistencies in the way people were supported with eating and drinking.

The needs of people at risk of poor nutrition were not effectively managed. Assessments and reviews of people's nutritional requirements had not been carried out as their needs changed.

Care workers told us that they found the electronic care records difficult to access and relied mostly on the handover book. This meant that people who used this service may not have received appropriate and safe care that met their wishes and expectations.

We found that there had been some improvements in the way medicines were managed and handled but there were inconsistencies in the safe administration and management of topical medicines such as ointments, creams and lotions. Information and staff understanding regarding the use of "when required" medicines was unclear. This meant that people who used this service may not always have received their medicines as their doctor intended.

Care workers told us that they were well supported by the registered manager. We noted that they received regular supervision and appraisals and that staff meetings took place. However, there were some shortfalls in the staff training records and training plan. Staff had not had their skills updated for some time and the training plan gave no indication as to when training would take place.

There were three people living at Stanbeck who were subject to Deprivation of Liberty safeguards. One of these people had been supported appropriately by an independent mental capacity advocate because they had no representative to help them.

We checked the information we held about Stanbeck. Care homes are required to notify us about any applications they make to deprive a person of their liberty under the Mental Capacity Act 2005 and about the outcome of those applications. They are also required to notify us of other incidents that affect the health, welfare and safety of people who use the service. The registered provider had failed to do this.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We spoke to Cumbria Fire and Rescue about some of the practices at the home, for example wedging open fire doors. The Fire Officer visited the home and offered advice on these matters.

There was a complaints process in place at the service. We did not receive any complaints during our visit to the service. We checked the information we held about the service, we found that we had not received any complaints during the last 12 months.

The registered manager had carried out various audits to monitor the quality of the service. Where shortfalls had been identified action plans had been developed to help drive improvements to the service. People who used the service were able to comment on their experiences and quality of the service. We saw that this had been done via questionnaires.

We found breaches of the following Regulations:

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have a plan of care and support that had been specifically personalised for them. This meant that the care they received may not always have met their needs or reflected their preferences . You can see what action we told the provider to take at the back of the full version of this report.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk because the registered provider had not assessed the risks to the health and safety of people receiving care and support. You can see what action we told the provider to take at the back of the full version of this report.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of not receiving their medicines safely or as their doctor intended. You can see what action we told the provider to take at the back of the full version of this report.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not properly protected from the risks of abuse or improper treatment because the registered provider did not have robust systems and processes in place. Staff had not been provided with proper training about keeping people safe. You can see what action we told the provider to take at the back of the full version of this report.

Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of receiving inadequate support with their nutritional and hydration needs. The registered provider had not ensured people had received assessments and reviews of their nutritional needs and could not demonstrate that appropriate food and drink had been provided to meet those needs. You can see what action we told the provider to take at the back of the full version of this report.

We have made a recommendation that the service seek advice and guidance about providing information to people who use this service, in a format that meets their needs.

We have made a recommendation that the service considers current guidance with regards to current health and safety legislation.

We have made a recommendation that the service finds out more about training for staff, based on current legislation and best practice, in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

We have made a recommendation that the service finds out more about training for staff, based on current best practice, in relation to equality and diversity.

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 safe.

The registered provider did not have robust systems and up to date safeguarding processes in place. This meant that people who used this service were not always effectively protected from potential abuse and improper treatment.

The registered provider did not assess, and keep under review, the risks to the health and safety of people who used this service.

Medicines were not consistently managed and care workers had not been kept up to date with their training.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received support and supervision from the registered manager. However, they were not consistently provided with appropriate training to ensure their skills and knowledge were kept up to date.

The nutritional needs of people who used this service were not effectively managed. Assessments and reviews of people's nutritional requirements had not been carried out as their needs changed.

Is the service caring?

Good

The service was caring.

Staff were respectful of people's privacy and dignity and only intervened when necessary or when people requested their help.

People had made decisions about the type of care and support they would like at the end of their life. Appropriate help had been provided for people who needed support with the decision making processes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The people who lived at Stanbeck did not have a plan of care and support that had been specifically personalised for them. This meant that the care they received may not always have met their needs or reflected their preferences.

People told us that there were activities and social events available at the home should they wish to join in with them.

The registered provider had a process in place for dealing with complaints and concerns. The format of this process may not meet the communication needs of people who used this service.

Is the service well-led?

Requires Improvement

The service was not always well led.

Accident and incident recording and reporting were not effectively monitored and managed.

The registered manager had carried out a variety of safety checks and audits to help ensure the home was safe. Action plans had been developed to help the registered manager keep on track with making improvements to the standard of service provided.

People who used the service, staff and visitors to the service were all aware of who the registered manager was. They all said that they were confident in speaking to the registered manager if they had a problem or concern.

Stanbeck Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 May 2016 and was unannounced.

The inspection was undertaken by one lead, adult social care inspector.

Prior to our inspection visit we looked at the information we held about this service. This included the action plan sent to us by the registered provider and notifications, sent to us by the provider, about significant events that had happened at the home.

Before the inspection, the registered provider completed a Provider Information Return (PIR). 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.

During the inspection we spoke to people who used this service, visiting relatives and health care professionals. We spoke to the staff on duty at the time of our inspection, including the registered manager and the two staff going off night duty.

We looked in detail at the care records belonging to three of the people who lived at Stanbeck and we reviewed the personnel records of two members of staff. We looked at a sample of records that the registered provider is required to maintain in respect of safety and quality monitoring. We observed staff supporting people with their care needs and we looked at the general environment at Stanbeck.

Requires Improvement

Is the service safe?

Our findings

One of the people who used this service told us; "The girls are mostly OK. Some can be a bit brusque but they are OK." This person declined providing any further details about the "brusque" staff. However, they did add that "The staff are mostly kind and help me when I need them."

Another person told us: "The girls (staff) are very nice. They help with everything I need. I feel safe here. If something is not right or people were unkind I would tell the registered manager."

A third person commented: The staff make sure I am safe. My clothes are clean and my room is kept clean. I am treated kindly and the lasses (staff) sort out any problems I might have."

Two other people who used this service commented that there were "enough" staff to "look after" them.

One of the visitors to the home that we spoke to told us that they visited regularly and at different times of the day. They said; "My relative appears to be well looked after. I have no concerns about the staff and have never seen or heard anything untoward."

We spoke to a health care professional who was visiting the home on the day of our inspection. They told us that they had "no concerns" about staff competency and had "never seen" anything untoward or poor practice from staff.

Prior to our inspection of this service we checked with the local social work team. They told us that they had not received any reports of allegations of abuse from this service and that the service was "very quiet."

We checked that the registered provider had procedures in place with regards to safeguarding vulnerable adults. The procedures were out of date and provided information that was unclear and inaccurate. We checked that staff had received training to help them understand abuse and about safeguarding people. We found that more than half of the staff employed at the home had not received this type of training. When we spoke to staff about their training and safeguarding processes, they did not confirm that they had received this training. However, they were able to tell us about the various forms of abuse and that they would report any concerns to the registered manager.

When we looked at the sample of care records belonging to people who used this service, we noted that there were instances of "unexplained" bruising recorded. We could find no evidence that these matters had been reported or investigated appropriately in order to rule out potential abuse from either staff, self-harm or other people who used the service.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not properly protected from the risks of abuse or improper treatment because the registered provider did not have robust systems and processes in place. Staff had not been provided with proper training about keeping people safe.

We looked at a sample of care records belonging to three of the people that used this service. We found that all three people had suffered numerous falls at the home, most of which had been unwitnessed. This meant that staff did not know the cause of the fall or whether the person had been unconscious for any length of time. The records showed that people had been checked over by staff at the home and assisted up from the floor. Of the 32 falls recorded within the three care records we looked at, only two had resulted in medical interventions.

Not everyone in this sample had a falls risk assessment in place, and those who did, had not had their risk assessments reviewed and updated following a fall. Reassessment would have helped to identify and mitigate any further risks.

We checked the information we held about this service and found that the registered provider had not notified us about accidents and incidents that had occurred at the home. We compared the significantly low number of notifications to other similar providers. This indicated that the registered provider was not always reporting when they should do. If they are not reporting promptly, they may not be analysing incidents and (where relevant) learning from them.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk because the registered provider had not assessed the risks to the health and safety of people receiving care and support.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We looked at the registered provider's medication policy and procedures and we looked at the way in which the service managed the administration of medicines.

The home's supplying pharmacist had provided the registered manager and staff with a comprehensive file of patient information leaflets. This provided staff with important information about people's medication, including what the medicine was for and of any side effects.

We observed that medicines were stored appropriately and securely. We carried out a random sample check of people's medicines and medication administration records, including medicines that were liable to misuse (controlled drugs). There was a designated fridge for the storage of medicines that required cool temperatures. The fridge temperature readings were acceptable on the day of our inspection but we could not check the consistency of this as staff told us daily checks and records were not maintained.

There were adequate processes in place for receiving medicines into the home and for the disposal of unused medication. Medication administration records were mostly completed and up to date. There were some inconsistencies with the way in which topical creams and ointments were managed. Some people had detailed body maps and care plans to help care workers manage people's skin care safely and appropriately whilst others did not.

We asked the care worker administering medicines on the day of our inspection about how "when required" medicines were managed. We were told that the only medication of this type in use were "painkillers." The care worker told us that people who used this service were asked during the medication round or would ask themselves, if they needed this type of medicine. In the sample of care records we checked there were no plans or instructions for staff to follow regarding the use of this type of medicine.

One person's records showed that they received their medicines in yogurt. It was not clear from the records whether or not this medicine was being administered covertly. Checks had not been made on the mental capacity of this person with regards to making decisions about their medicines. Furthermore, the pharmacist had not been consulted, which is contrary to good practice, to advise on the stability of any medicines that needed to be crushed or mixed with food or liquids.

The 16 care workers responsible for the administration of medicines had received training with regards to medicines administration. However, the staff training matrix recorded that 14 of these care workers had not received any updated training for several years. The training plan that the registered manager gave us did not include any plans to update care workers in the safe management and administration of medicines.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of not receiving their medicines safely or as their doctor intended.

We spoke to people who used this service and care workers on duty during our inspection of Stanbeck, about staffing levels. We observed that the care workers were very busy throughout the day. No one raised any issues or concerns. Care workers told us that they had; "Time to give care because it is a small home" and people who used the service all said that the staff "usually" attended to them "very quickly."

The registered manager was in the process of recruiting some new members of staff. We looked at the process for doing this and sampled the recruitment records. We found that the registered manager had carried out all of the necessary checks to help ensure only suitable people were employed to work at Stanbeck.

One housekeeper was employed at the home over three days per week. Care staff and the registered manager carried out the domestic duties at the home on the remaining days. There were cleaning schedules in place and on the day of our visit the home was generally clean and tidy. There were no unpleasant odours. One of the people who used this service particularly commented on the good standard of cleanliness of their room.

Requires Improvement

Is the service effective?

Our findings

One of the people who used this service, who we spoke to, told us that they had special needs when eating and drinking. They told us; "The speech and language therapist has been happy with what has been done here with regards my eating and drinking."

People who used this service also commented;
"The food is alright. I get enough to eat and drink. If I want a sandwich or a drink during the night the girls (staff) get me one."
"My lunch today was quite nice. The food is always very good."

The health care professional that we spoke to during our visit told us; "The staff appear competent and they always follow any instructions I leave. I have never observed any poor practice during my visits to the home."

The care workers we spoke to during our inspection of the service all told us that they had been provided with training. The examples of training they gave us included; restraint, health and safety, moving and handling and first aid training.

We checked the information that the registered provider had included in the PIR and compared this with the staff training matrix that the registered manager sent to us. There were some discrepancies in the numbers of care workers who had received training and we also noted that some training had not been updated for several years.

The care workers that we spoke to told us that they were well supported by the registered manager. They said (and we saw from personnel records) that they received regular supervision and appraisal. Staff meetings took place and, we were told, the registered manager checked staff competencies.

The care workers met daily with the registered manager and said that any issues raised were dealt with quickly. There was a handover book that was used to communicate information at each staff shift change. However, one of the care workers we spoke to said; "There's not always a lot of information recorded in the handover book. We are expected to read this book on return from holiday or a long break from working to help keep up to date with people's needs."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA).

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 so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met .

The registered provider had a policy and procedure in relation to the Deprivation of Liberty Safeguards. This included the need for staff training, the process for applying for authorisation and the need to keep this under regular review.

There were three people living at Stanbeck who were subject to a DoLs. One of these people had been supported appropriately by an independent mental capacity advocate because they had no representative to help them.

The registered manager appeared to have followed the principles of the MCA 2005. However, none of the care workers, including the registered manager, had received any training with regards to the Mental Capacity Act 2005 and the DoLs. This training had been included in the training plan but there were no dates indicated to confirm when this important training would be provided.

We recommend that the service finds out more about training for staff, based on current legislation and best practice, in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We looked at the ways in which people were supported with their nutritional and hydration needs.

The registered provider did not employ a cook or kitchen staff. We observed that the two care workers on duty also carried out the catering duties and clearing away after meals. The registered manager confirmed that the home did not employ a cook and that any of the staff were able to do the cooking. The registered manager said; "We have tried having a cook but it didn't work. The staff like to do this (the cooking) as part of their job."

We spoke to the care workers who had prepared and served lunch on the day of our inspection. They told us that they had received food hygiene training and showed us the systems in place to help ensure food was stored, prepared and cooked correctly. The kitchen had been inspected by the local authority food safety officer and had been awarded a rating of 4 stars – Good.

We noted that care workers changed their aprons when serving food and washed their hands. However, one of them was wearing nail varnish and this is poor hygiene practice.

We observed care workers serving meals to people in the dining room or in their own rooms. We noticed that there were some very nice interactions between staff and people who used this service during the lunchtime meal. Care workers only intervened when people needed assistance. The dining room at lunchtime provided a pleasant and sociable environment.

We looked at care records relating to the nutritional needs of three people who used this service. The sample of daily notes we looked at recorded concerns with people's dietary needs. When we checked their nutritional care plans, we found that these had not been reviewed and updated to reflect people's current

nutritional status. One person had been referred to the dietician for advice and support with their nutritional needs because of weight loss. Food and fluid intake records had been completed by staff at the home to help monitor this persons eating and drinking habits. However, these had been poorly maintained and it was impossible to tell from the records exactly how much this person had actually eaten or drank. There was no evidence of nutritious snacks being offered and where meals had been recorded as "refused" there was no evidence to support that this person had been offered alternatives or meals at a later time.

Another person's records showed that they had lost a significant amount of weight over a four month period. Their nutritional assessment and care plan had not been reviewed or updated and there were no records to confirm that this person had been referred to or reviewed by the dietician.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of receiving inadequate support with their nutritional and hydration needs. The registered provider had not ensured people had received assessments and reviews of their nutritional needs and could not demonstrate that appropriate food and drink had been provided to meet those needs.

When we arrived at the home we noted that all of the main doors in the home had been wedged open. The majority of these were fire doors. The registered manager told us that the doors would be closed once everyone was up and about. However, this was not the case and the doors remained wedged open for the duration of our visit. We spoke to Cumbria Fire and Rescue about these concerns.

We also noted that the windows at the home had not been fitted with appropriate window restrictors to help prevent people accidentally falling out.

We recommend that the service considers current guidance from reputable sources to ensure the home is compliant with health and safety legislation.

All of the bedrooms at Stanbeck had en-suite facilities and all were used for single occupancy. There were a variety of communal areas at the home including lounges, a dining room, adapted bathrooms and toilets and gardens. The accommodation was provided over two floors and first floor was accessible via the stairs or a passenger lift. At the time of our inspection the home was clean and tidy and there were no unpleasant odours.

The home was well equipped with handling equipment to help ensure people who needed assistance with their mobility, were supported safely.

Good

Is the service caring?

Our findings

One of the people we spoke to during our inspection of Stanbeck told us; "The girls (staff) are very nice and very kind. They come to me quickly when I need them to help."

Another person said; "I didn't want to come into a home at first now I don't want to go home. I am very happy here. The staff are very good and help me when I need it."

We observed care workers supporting some of the people who used this service. We noted that staff were respectful of people's privacy and dignity and only intervened when necessary or when people requested their help.

We saw that most of the people who used this service appeared well groomed and well cared for, although there was one person we visited whose room was not clean and they had food spilled all down their clothing. This person would have needed staff assistance with these tasks.

We observed staff using handling equipment and providing explanations to the people using it. This helped to reduce people's concerns and anxieties when staff were supporting them with their mobility.

Wherever possible, people were able to remain as independent as possible. Where people required help with their daily needs, staff enquired discreetly and provided such support in the privacy of people's own rooms.

Care workers had received training about promoting dignity during personal care procedures. The care workers we spoke to during our inspection appeared to know the people who lived at Stanbeck very well and were able to give us verbal updates about people's needs and support required. One care worker told us; "I think we have time to give care to the people here because we are a small home and are not rushing about."

On the day of our inspection, there were no people at the home who were requiring special support because they were coming to the end of their life. We noted that some people had made decisions about the type of care and support they would like at the end of their life. One person had been supported by an independent advocate with some of their decision making processes.

We spoke to a health care professional who was visiting the home during our inspection. They told us that service accessed their help and advice "appropriately". They also said that the service "always" followed any advice or instructions left about the care and support of people who used this service.

Care workers had not received any training with regards to equality and diversity. The registered manager had identified this as a training need on the home's training plan for 2016, but there was no indication as to when this type of training would be provided.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

One of the people that used this service told us: "I can have visitors to see me any time I like."

Someone else who lived at Stanbeck said; "I like to go outside. I went out into the garden the other day, but of course you have to wait for staff to be free to take you out."

Another person said; "I like to stay in my own room, I'm very happy here. I will go upstairs and join in the activities if it is something I am interested in."

One of the visitors we spoke to during our inspection of the home said; "There seems to be plenty of things for people to do here. It is a small home and I think the people who live here get more attention."

The registered manager told us about a new system that was being introduced into the home, with the intent to create a more seamless service for the people who lived at Stanbeck. The electronic recording and monitoring system was designed to include links to NHS services, GP's, social workers and make referrals to the podiatrist for example.

During our inspection of Stanbeck we looked, in detail, at the care records of three people who used this service. The records had been kept electronically and the registered manager helped us to access this information.

We found that care records were not well maintained. Information about people's individual care needs and personal preferences were poorly recorded. Care plans and risk assessments were out of date and had not been reviewed and updated as people's care and support needs changed. This was particularly noticeable where people had been identified as being at risk of falling, developing pressure ulcers and at risk from poor nutritional intake.

Staff told us that the care records were difficult to access and that they had received little training on the computer systems. Staff mostly relied on the handover book to update themselves about people's care and support requirements and any changes that there may be. One member of staff said that there was "not always a lot of information written in the handover book."

The staff that were on duty during our inspection of Stanbeck were able to give us a verbal update about the needs of people they were supporting. People who used this service were treated gently and with kindness by staff who were well meaning in the way in which they provided care and support.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service did not have a plan of care and support that had been specifically personalised for them. This meant that the care they received may not always have met their needs or reflected their preferences.

Everyone we spoke to during our inspection confirmed that they knew who to speak to if they needed to raise concerns. One person told us about a concern that they had raised with the registered manager. They confirmed that the matter had been dealt with to their satisfaction.
The registered provider had a complaints procedure in place a copy of which was placed on the notice board in the home. Although the procedures were accessible to everyone at Stanbeck, the format of this important document did not meet the communication needs of all of the people that used this service.

We recommend that the service seek advice and guidance from a reputable source about providing information to people who use this service, in a format that meets their needs.

We checked the information we held about this service and we checked with the local authority's adult social care team. We found that no complaints had been made about this service to either CQC or the local authority. The registered manager had provided us with information about Stanbeck prior to our inspection visit; this information also showed that the service had not received any complaints in the last 12 months.

Requires Improvement

Is the service well-led?

Our findings

All of the people we spoke to during our inspection of this service knew who the registered manager was.

People who used the service and visitors to the home told us that they would speak to the registered manager about anything they were concerned about. Staff told us that they met with the registered manager daily. They said; "It is a small home and the manager often works alongside us. We deal with issues as they arise. The manager is very approachable."

The registered manager told us that she was on call all day, every day and was accessible to staff at any time.

The staff also told us that they had more formal meetings with the management and that their competence and practice was monitored.

We looked at a sample of health and safety records that the home is required to maintain. Including accident and incident records. We compared these to the information we held about this service. We found that the registered provider and registered manager had not been notifying us about these matters as required. If they are not reporting promptly, they may not be analysing incidents and (where relevant) learning from them. We found that risk assessments had not been reviewed and updated following incidents such as falls, for example. This further added to the evidence that the registered persons were not effectively monitoring and managing the safety of the service.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We found that moving and handling equipment had been appropriately serviced and checked.

The registered provider carried out monthly audits and checks on the management of medicines, including the correct completion of administration records.

Fire prevention and firefighting equipment had been frequently serviced and checked. The provider had a fire safety action plan. When we looked at this document there were some areas of concern. However, we spoke to Cumbria Fire and Rescue service about these matters. They visited the home and reported back to us that they had no major concerns with the fire safety at the home and that they had spoken to the registered manager about the wedging of fire doors.

The registered manager had recently carried out an audit to check the effectiveness and implementation of the home's infection control and prevention procedures. The audit had highlighted areas for further improvement and the registered manager had developed an action plan to help ensure improvements were made.

People who used this service and visitors to the home told us that there were no formal meetings held. However, people knew who the registered manager was and were "confident" that she would "listen and act" on any concerns or suggestions raised. The registered manager had recently carried out a quality check on the service. This had included sending questionnaires to people who used the service, their relatives and to external health and social care professionals who visited Stanbeck. The comments and outcomes of the quality checks were mostly positive. Where suggestions had been raised, for example regarding meals and missing laundry, the registered manager had put things in place to make improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: People who used this service did not have a plan of care and support that had been specifically personalised for them. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used this service were placed at risk because the registered provider had not assessed the risks to the health and safety of people receiving care and support. People were placed at risk of not receiving their medicines safely or as their doctor intended. Regulation 12(1)(2)(a)(b)(c)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used this service were not properly protected from the risks of abuse or improper

	treatment because the registered provider did not have robust systems and processes in place. Staff had not been provided with proper training about keeping people safe Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who used this service were placed at risk of receiving inadequate support with their nutritional and hydration needs. Regulation 14