Excelsior Health Care Limited

Stanton Hall Care Home

Inspection report

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20 September 2017

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

Summary of findings

Overall summary

This inspection visit was unannounced and took place on the evening of the 19 September and throughout the day on the 20 September 2017. At our last inspection visit on 5 October 2016 we asked the provider to make improvements to fire safety, staffing levels and the management of the home. The provider sent us an action plan on 22 April 2017 explaining the actions they would take to make improvements. At this inspection, we found improvements had not been made. The service was registered to provide accommodation for up to 45 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 22 people were using the service. The previous three inspections have identified that improvements are required. Despite taking actions to address the specific breaches in regulations, there has been insufficient improvements in the quality of care to people receive to ensure sustainable compliance with the Regulations. The overall rating for this service is Inadequate which means it will be placed into 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.

The service had did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had employed a new manager in March 2017; however they had not completed their registration. After the inspection the provider informed us this manager had left their employment. The provider told us they would be placing a temporary manager in place until they could recruit another manager to the home.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found that staff had not received recent training in safeguarding adults and showed limited understanding. Some staff had not received training as part of their induction; this meant staff had not been

given the skills to support their role.

People had not been protected from sore skin and when they required the use of equipment, we could not be sure the correct piece of equipment would be used. The majority of staff had received training in moving and handling, however evidence on the day of the inspection identified that staff were not using equipment correctly.

We found people's medicines had not been managed safety. Some people had not received their medicine and the stock of medicines was not monitored. The medicine recording sheets had not always been completed correctly and when medicine was disposed of we could not be sure this was in line with guidance. Some people required thickener in their drinks to reduce the risk of choking, we saw that generic thickener was used, which meant we could not be sure the consistency would be correct for each person.

There was not enough staff to support people's needs. Staff were unable to be responsive and people had to wait to receive personal care support. Care plans did not demonstrate people's involvement and the plans were not up to date.

The service could not demonstrate how they sought people's opinions on the quality of care and service being provided. People were not always stimulated in meaningful daytime activities and we saw there was a lack of opportunities for people to participate in activities.

Care staff did not feel supported in their role. There were no quality assurance systems in place to identify areas that needed improvement.

The provider was not meeting the Care Quality Commission registration requirements. They had not send notifications to CQC for notifiable incidents, such as serious injuries.

People had mixed views about the staff and the level of kindness. Some people had their dignity compromised. We saw that some staff used language which was not dignified. This language is not personal or reflective of a caring and a compassionate approach to people's needs.

We found the service had a policy on how people could raise complaints about care and treatment however there was no evidence to demonstrate how complains had been received and dealt with.

The rights of people who did not have capacity to consent to their care had been protected and the provider followed the associated guidance. People had access to healthcare professionals as required to meet their needs. We saw that the previous rating was displayed in the reception of the home as required. People enjoyed the food and their weight had been monitored.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009.
Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe
There was not enough staff to support people's needs. Medicines were not always managed safely to ensure people received their medicine as required. Equipment was not always used correctly to support people and people's skin was not always protected. Staff had not always reported safeguarding's and there were no systems in place to manage the concerns raised. Risk assessments were not always followed in relation to recruitment to ensure people were safeguarded.

Is the service effective?

Requires Improvement

The service was not always effective
Staff had not always received training that helped them offer support to people and develop their role. People had been supported to make decisions. The provider had considered when people were being unlawfully restricted and had made applications to the local authority. People enjoyed the food and were offered a choice and given support to maintain their specific diets. People had access to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring
People's dignity was not always respected and they had limited access to the garden and the community. People received care from staff who were friendly and kind. Relatives were welcome to visit anytime.

Is the service responsive?

Requires Improvement

The service was not always responsive
People did not receive care that was responsive to their needs. Handover information did not ensure people received care which was current for their needs. There were limited activities to stimulate people. There was a complaints policy in place, however there was no evidence to demonstrate how complains had been received and dealt with.

Is the service well-led?

Inadequate

The service was not always well led

There was not a consistent approach to the management of the home. The provider had not sent us statutory notifications for notifiable incidents as required by their registration. Processes to assess safety and quality assurance were not effective to cover all areas of care practice. Staff did not feel supported in their role and some staff had not received the checks required to ensure they had information to ensure peoples safety. There was a mal odour in the home and consideration had not been made with regard to maintenance of the home. Ongoing concerns identified by social care providers had not been addressed.

Stanton Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection visit 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.

Our inspection was unannounced and the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion, we had not asked the provider to send us 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.

This comprehensive inspection had been brought forward as a result of information received from whistle-blowers, the Derbyshire safeguarding team and the local authority. We used this information to formulate our inspection plan.

We spoke with seven people who used the service and six relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We also spoke with three care staff, two seniors, two agency nursing staff, the cook and the manager. Throughout the inspection the operations director was on site and was joined by the provider for part of the day. After the inspection we spoke with health care professionals and social care staff to reflect on the care people received.

We looked a range of information and care records for eight people who used the service. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. Following the inspection we asked the provider to share with us information which was not available on the day. The provider told us this information was not available and therefore

we were unable to clarify some areas of the inspection.

Inadequate

Is the service safe?

Our findings

At our previous inspection in October 2016 we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured sufficient staff were available to meet people's needs. At this inspection we found that the required improvements had not been made.

We had identified at the last inspection some people did not receive their breakfast and care support until late in the morning. We saw at this inspection this practice continued. A relative said, "We have been on several occasions and [name] is not up at 11.30 a staff member had told us this was due to the lack of staff." We saw one person did not receive their breakfast until 11.35am and then they received their midday meal at 12.15pm. Three other people were not supported until after 10.30am for their personal needs. Staff we spoke with confirmed this. One staff member said, "We need more care staff, especially at weekends. People are not able to get up early enough, due to staffing levels." Another staff member said, "People are not able to get up when they want and we have more people with support needs."

Some people had been identified as requiring one to one support from staff. This was due to them placing themselves and others at risk of harm. We saw at the inspection on the 19 September this one to one position was not covered from 7.00pm to 10.00pm. During the evening, the allocation for care staff was two in the main house and one in the Stanhope unit. Whilst the two care staff supported people to bed, between 9.00pm and 10.00pm we saw there remained six people in the lounge unsupervised. This included the person that was funded for one to one support.

During this time we saw some people requested to go to bed, however they were told they had to wait until it was 'their turn.' In the Stanhope unit three people required two staff members when they needed personal care. When the second person was required the staff member had to call the main house for support. This left one carer to support the 18 people within the main house.

We saw during the morning on the Stanhope unit, on two occasions people waited 15 minutes and during the afternoon the administrator had to seek a carer to assist as the call bell had not been responded to and the person was waiting. We saw other people had to wait for their care. One person said, "They don't always take me when I ask and they don't always come in the night."

We saw during the afternoon that one person attempted to climb out of a downstairs full length open window. This double window was held open by a chain restrictor, however a person could still access out through the window. A relative alerted the staff member to the situation, who supported the person back inside. This meant the provider had not ensured sufficient staff were available to support people's needs.

This demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in October 2016, we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured appropriate provision for fire evacuation. The fire service had issued an enforcement notice to the provider and they had completed all the actions required to meet that notice. However, some staff had not seen the individual evacuation plans for people and they confirmed to us that no evacuation drills had been completed. This meant that there could be a delay in evacuating people from the home.

There was no evidence to demonstrate that people were supported to ensure their skin was protected from sores. For example, one person received a check in their room at 4.00am; their next check was at 10.45am. Their care plan identified they should be supported every 2 hours for pressure relief. Other people had been prescribed pressure cushions to reduce the risk of sore skin; we saw that some people were not supported to use this equipment. Throughout the day of the inspection, pressure relief to some people was not given or recorded.

Some people required the use of a hoist to support their transfers and had been issued with individual slings which were named. We saw that the designated sling had not been used for two people. One person required their sling to be left in position. We saw the staff had removed the sling. We asked the manager about this action and it was identified the staff had used an incorrect sling for this person. Later in the day this person had to be supported to have the correct sling position under them in preparation for their transfer, the person showed distress and discomfort whilst this took place. This could have been avoided if the correct sling had been used initially, as it would have remained in place to reduce the person's anxiety. It also meant we could not be confident the correct equipment was used to support people safely.

People had not been encouraged to mobilise. One relative said, "When [name] first came they did say they would get them walking, but they didn't. I think it's easier for them to leave them in the chair." We saw staff using wheelchairs to support people and observed no one was encouraged to be more independent. We saw one person was discouraged from walking about. This person's care plan identified they used a walking aid. The aid was only offered, following our request. Another person who lacked capacity was being restricted by a table to stop them standing up or leaving the chair. Other methods of support had not been considered.

Medicine was not managed safely. For example, one person had not received their medicine and this was due to there being no remaining stock for this medicine. Some medicine administration records had not been completed correctly. For example, MAR showed some missed signatures and one person had received their medicine which had been signed for on the incorrect day. We also saw that some medicine remained in the blister pack; however this had been signed as being administered on the MAR. This meant we could not be sure the people had received their medicine as prescribed.

We checked the stock of some medicines and found that the stock did not tally with the MAR. Some medicine was over the stock numbers recorded and others were below the required number of medicines that should have been in stock. This meant we could not be sure people received their medicine as prescribed. The medicine trolley was stored in the space at the bottom of the stairs. There was no thermometer in the trolley to ensure that the medicine was being stored at the correct temperature in line with storage guidance for medicines.

Some people required a prescribed thickener for their drinks to reduce the risk of choking. These thickeners are specific to each person and are issued on prescription. They include information which identifies the amount of thickener required for each person. We saw that a thickener prescribed for a person that was no longer at the home was being used for everyone that required their drinks to be thickened. This meant we

could not be sure the correct consistency was being given to each person in line with their prescription.

This demonstrates a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not always received training in relation to safeguarding. This meant that we could not be sure staff had the understanding of how to recognise signs of abuse, the actions they should take and when to raise a safeguarding referral. For example, there had been two incidents which had not been referred to the local authority safeguarding team as required. This meant these incidents had not been reviewed by the team to assess the risks and take action to keep people safe from harm.

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. A risk assessment was in place for one staff member that identified they could not work unsupervised. However we saw that this staff member supported people with personal care on their own and had worked in the Stanhope unit where staff worked independently. This meant we could not be sure that the provider had followed their own risk assessments in safe recruitment practices.

Requires Improvement

Is the service effective?

Our findings

Staff had not always received training for their roles. At the last inspection fire safety was a concern. Two staff and agency staff we spoke with had not received fire training. This meant that they may not be aware of how to evacuate people in case of an emergency.

One staff member had been on a fire awareness course to become the fire marshal. They had attended training at another home owned by the provider. However on returning to the home they had not used their knowledge to familiarise themselves with the fire evacuation requirements at Stanton. This meant they would be unable to support the evacuation of the home as they had not reviewed the evacuation procedures in line with their training. The manager acknowledged that they needed to give staff the opportunity to put into practice the training they have received to support their role.

We observed staff supported people to move, this was an area identified by several safeguarding concerns from the local authority. The provider had instructed all staff to receive moving and handling training, which we had been told was completed. However we saw that staff used the incorrect slings for people. One staff member told us they had only received the theory in relation to moving and handling training and not any practical training. They confirmed they had observed other staff and worked with them in supporting people to transfer using equipment. This meant we could not be confident that people were supported to move by trained staff and our observations on the day of the inspection identified that staff were not using equipment correctly.

New staff had not received mandatory training ahead of their start date. Staff we spoke with had been working at the home for three or four months and had not completed their initial training. Staff told us with the exception of the moving and handling theory all the training was provided on a DVD. The staff member said, "I would like more hands on training." The manager told us that moving forward staff will complete the DVD training ahead of starting. This meant we could not be sure staff received the training they required for their roles.

This demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

We checked to see if the provider was working within the principles of the MCA. We saw when people lacked capacity to make certain decisions for themselves mental capacity assessments were in place. We also saw that best interest decisions had been completed for example, use of equipment and support with medicines. Staff we spoke with demonstrated an understanding of the Act. One staff member said, "Some people cannot process information verbally, so I write it down, so I can ensure the person has a choice."

The provider had considered when people were being restricted unlawfully and applications when needed had been made to the local authority. We saw that capacity assessments and best interest decisions had been completed ahead of the application. The manager had a system in place to record DoLS applications and any implications before or after authorisation. This meant the provider ensured they followed the guidelines within the Act.

People and relatives told us they enjoyed the meals. One person said, "You get two choices. You can have a full cooked breakfast if you want one." A relative told us, "I think it's good, there's a nice choice and always something hot." Another relative told us, "I join [name] every Sunday for the roast it's lovely."

We saw that people had their weights monitored and when a concern was raised a referral had been made to the speech and language team. Guidance from this team was followed and we saw in the kitchen there was a board which identified the different dietary needs people required. When people required a meal in a softer form this was provided and presented in pleasing way. People received support with their meal if required.

People were supported with their health care when needed. One person said, "I had not been her long when I had my toes done. I'm waiting to go to hospital in October for my eyes to be tested and I go every 6 months to the dietician." A relative said, "They have been to the hospital twice, they don't hesitate. They have seen a physiotherapist." We saw records which showed people had been referred and information recorded in their care plans. This meant people were supported with their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always respected. For example, we observed one person asleep in an armchair all morning. They were lent over to one side in their chair. We saw that no staff member approached this person throughout the morning. During the mid-morning drink, this person was not woken or offered a drink. At midday we raised our concern for this person. A staff member then supported the person to sit up. The person verbally expressed their discomfort and their facial expression showed they were in pain.

People had not been supported to access the community by the provider. For example, some staff had taken people to the cinema however this was in their own time. There was a large garden with a sensory garden, however there was no easy access to this and people could only access it if accompanied by a staff member.

We saw that some staff used language which was not dignified. For example, we heard staff referring to some people as 'feeders' and 'the next one or them'. This language is not personal or reflective of a caring and a compassionate approach. This demonstrated that staff were not always considerate or respectful towards people.

People told us staff knew them well and had established relationships with them. One person said, "They're brilliant, you can't fault the staff here, they go out of their way here to be kind." A relative said, "They're all nice really. The young ones as well as the more mature ones." Another relative said, "I cannot fault the staff." We saw when staff approached people they spoke with them in a caring way. One person said, "You're a good bunch of carers here, who make it easy for us?." Another person said, "We have a laugh and a joke."

Relatives told us they felt welcomed and relaxed at the home. One relative told us, "I come at different time, always welcome." We saw that people who mattered to the person had been included in discussions and decisions at their request. One relative said, "They have contacted me when they had a fall and any other information."

Requires Improvement

Is the service responsive?

Our findings

People told us staff did not always respond to their needs. One person said, "The staff don't always come at night if you press your buzzer." Relatives commented, "There is a bracket there for an emergency bell, however there has never been one in here. The staff walk through and often don't acknowledge people." They added, "Often when you go into the other lounge there is no staff around as they are getting people up." We saw that the small lounge was not supervised and there was no opportunity for people to press a call bell if they required assistance. One person said, "You have to shout loudly if you need someone."

A relative told us about an incident when the lift had broken. They told us, "I wasn't happy that [name] had been left sitting in the wheelchair." We saw and this relative confirmed that the person had remained in their wheelchair on the day of the inspection since lunch time. Their relative told us at 3.00pm, "[Name] has been left sitting in the wheelchair since dinner, and to me they should be in a proper chair."

People did not always receive stimulation throughout the day. We saw the provider had recruited an activities coordinator; however they had not provided them with any training. One relative told us, "What really gets me is when [name] is on their bed; they get no stimulation at all." They added, "I did mention this to the owner that there could be more stimulation, especially in the bedroom and they said like what?" We saw the activities person had brought in books to read to people, however these people were unable to engage in this activities due to their level of attention and cognitive awareness. Three people were encouraged to participate in a game of throw and catch with an easy grip ball. Most people sat in chairs around the lounge with little stimulation except the television or music via a CD. This meant people were not encouraged to engage in activities of interest to them.

In the Stanhope unit people felt more stimulated and had the opportunity of how they wished to spend their day. One person told us, "I do like my independence; I grow things on my patio and have strawberries growing. Chestnuts for the squirrels. I even go in the kitchen and make my own omelette and things like that, we do cookery and all that."

The staff completed a daily worksheet which covered any changes which occurred with people and any actions required by the next staff member on duty. However, this document was not use to plan the support for people. For example, people who had been in bed from 7.30pm had to wait until past 10.00am the next day to get up and we could not be sure they received any refreshments during this time. This meant we could not be sure people received continuous care.

There was a mixed response from people and those important to them being involved in the development of the care plan. One relative said, "I have been involved in the meeting." Another relative said, "I don't think I have, I would be involved if they feel they needed me to be." We discussed this with the manager and they noted this was an area they were developing as they renewed all the care plans.

There was a complaints policy at the home. The manager told us they had received only one formal complaint in the last 12 month which had been addressed. We asked the provider to send us details of the

complaint and their response post inspection. At the time of this report we have not been sent the information. Therefore we could not be sure the complaint had been dealt with in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

The leadership of the service was inconsistent and there was no registered manager at this location. There was a manager on site who had commenced their role in March 2017. During the last six months this manager who was a qualified nurse had been completing nursing shifts due to the shortage of nursing staff. It was agreed at the provider meeting chaired by the local authority in August 2017, the manager would be supernumerary to concentrate on the management of the home. However we saw from the staff rota the manager had still covered some nursing shifts. This manager had only received one supervision meeting and no formal probation meetings in relation to their role.

Over the last four years the home has not secured a manager for more than a period of one year. The previous manager, who was only at the home for five months, expressed their concerns to us stating there was a lack of support from the provider in enabling them to perform as a manager. For example, insufficient staffing levels to meet people's needs and equipment was not purchased in a timely manner. Since the inspection the current manager has left the company, stating that this was due to the lack of support from the provider which impacted on their ability to perform as a manager and ensure a safe environment for people.

We found the home had a mal odour on entry. At the last inspection in October 2016, we had commented on the mal odour in the home. The odour was most strongly noted in the main lounge area. We observed the domestic staff shampooing the carpet with vinegar. This created a strong unpleasant smell throughout this area. We asked the domestic staff to cease this activity as people were in the lounge eating their breakfast. They confirmed this was the cleaning method instructed by the provider. We noted throughout the home there were areas of thread bare carpet and the home looked in need of refurbishment.

We noted one wheelchair did not have footplates in position. A relative told us, "I took my relative to the hospital in a wheelchair from here. They told me they wouldn't let her come back in that chair as they said it wasn't up to standard."

Following concerns raised in relation to peoples safety we were invited to attend a meeting chaired by the local authority on 18 August 2017. At this meeting the provider agreed to complete an action plan and provide us with assurances in relation to the concerns raised. No members who attended the meeting had received a copy of the provider's action plan, but it was shared with us upon our request at the inspection on the 20 September 2017. The plan reflects the concerns raised and the actions the provider would take to resolve these. However areas identified by the provider as completed we found to still be of concern. For example, the recording of the pressure care for people and the daily logs. Some daily logs did not contain the date and time or the detail of the care being provided. This meant we were unable to confirm if people had received their pressure area care. Where daily logs had been completed they had not been used to reflect people's needs. For example, one person had been identified by staff as being sleepier than usual and felt they maybe unwell and this person had remained in their bed. None of the staff had reviewed the daily logs from the previous days which showed that the person had been awake for the majority of the s two previous evenings. This demonstrated that staff had not used this information to determine this

person's needs. -

A staffing dependency tool was in place. The action plan stated this had been reviewed on the 19 September 2017 and there was flexibility in relation to the staffing. At the feedback we discussed the staffing concerns at night. The operations director suggested the home could consider a twilight shift. The manager told us they had discussed this with the provider and they had not agreed to fund this role. In addition since our inspection the Stanhope unit had increased in numbers and therefore the level of the care needs of the people that used the service. We noted that three of the five people in this unit required two staff for their personal care needs and two people were at risk of choking so required supervision when eating and drinking. However the unit was supported by one staff member, who had to request help when it was required. We saw this had an impact on people's care during the inspection. Health care professionals had also commented that due to the inconsistent staffing, communication in relation to understanding people's needs was not always available.

Audits had been completed across a range of areas. However there was no evidence to show that the actions identified had been addressed. For example, it was identified that a staff member required moving and handling training. There was no date or evidence - provided to confirm this had taken place and competency checks completed. The infection control audit in July identified the need to replace some equipment, this had not been completed. Therefore we could not be sure that other actions identified had been addressed..

Some people expressed themselves in a way that placed themselves and others at risk of harm. The daily logs had identified one person had injured staff on several occasions; however no incident forms had been completed. The person had been prescribed medicine to support their anxiety, the lack of information meant the manager was unable to evaluate the impact or provide details to the health care professionals to consider the support for his person.

The provider was using agency staff as they had no regular nurses at night, weekends and some periods during the week. Not all the agency nurses had been to Stanton before and we identified that several of the nurses had not received an induction or completed the checklist in line with the provider's guidance. The last completed check list on an agency nurse was in May 2017. The Agency nurse present during the inspection had worked at Stanton on a previous single occasion in June 2017. On both occasions they had not been given an induction nor completed the check list. Staff were not adequately supervised. They told us they -had not received the support they required for their role. Staff had not received any supervision to support their role, to identify their training needs and any guidance they required. For example, we saw some staff referred to people in an inappropriate way. The provider had not identified this and given staff the correct training and guidance to know how to support people. Other staff had not received an induction or probation support with their role. Due to a high turnover of staff, many staff had only been at Stanton for three or four months. The provider's policy on the probation period for care staff is three months with a meeting at the six week stage. The staff we spoke with had not received any meeting or supervision for their role. The manager confirmed they were behind with supervisions.

We found that care records were not up to date. For example, some records had not been reviewed since July 2017. We also saw that some information that had been reviewed was incorrect. Health care professionals told us that the lack of information available impeded them being able to make decisions in relation to peoples care. For example, bowel medicine had been requested for one person, however the previous seven days of records had not been available, therefore it was unclear what medicine was required. They also noted medical history was often missing and staff did not have this information available to them. This meant we could not be sure information was being recorded to support people's needs.

People and relatives were unable to confirm if they had received any opportunities to provide feedback on the care they received and their opinions about the services provided at the home. It was agreed the information would be sent to us post inspection. At the time of this report we had not received this information. Therefore we could not be sure people and relatives had been given the opportunity to reflect on the home and for us to see how the provider had listened to people's views to drive improvements.

This demonstrates a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2016, we identified that notifications had not been completed during a period when there was no manager in post. At this inspection we identified that several notifications had not been completed in a timely manner. For example, one incident had resulted in a person being referred to safeguarding; we had not been informed of this incident. Other people had received hospital treatment due to injuries sustained in the home and this information had not been shared with us. One person had passed away and we had not been informed. This meant the provider had failed to report incidents relating to any possible impact on people's needs. We discussed the notification requirements with the manager and they agreed to send the outstanding notifications. However the manger left the home and the provider told us they were unable to provide the information we required.

This demonstrates the provider was in breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Staff told us they felt the new manager was approachable and provided them with support. One staff member said, "The manager is lovely and works really hard." Another staff member told us, "I feel I can go to her with any issues, they make things fair. She is very hands on." Since the inspection this manager has left the service. The provider has placed a temporary manager in post until they have recruited to this position.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating or offered the rating on their website

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 provider had not always reported significant events that occurred in the home. We had not received notifications from them for important information affecting people and the management of the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. People had not received pressure relief to support and maintain their skin. Peoples dignity in relation to equipment had not been considered and peoples independence had not been encouraged.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured a consistent leadership for the service. There had been no registered manager at the home for four years. the home was not well maintained and had a mal dour which was not addressed appropriately. Areas identified in a concerns meeting had not been addressed. the audit systems in place did not show when action had been completed to provide the confidence improvements were being made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times.