Care Quality Commission

Miss E Smith
Sandringham House
Inspection report

26 Sandringham Road, Lower Parkstone,
Poole BH14 8TH
Tel: 01202 744409

Date of inspection visit: 10,11 & 19 December 2014
Date of publication: 31/03/2015

Ratings

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

Overall summary

This was an unannounced comprehensive inspection carried out on 10, 11 and 19 December 2014.

Sandringham House is registered to provide accommodation for people who require nursing or personal care. The provider has chosen to specialise in caring for people living with dementia. The home is registered to accommodate a maximum of 16 people. There were nine people living in the home.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At this inspection we found there were shortfalls in a number of areas. Improvements were needed to ensure the service kept people safe and their rights were protected.

Policies about keeping people safe and reporting allegations of abuse were in place. However, these were generic and did not reflect local guidance. We found one instance where the safeguarding policy had not been followed. Staff training records indicated that most staff received training in how to protect people from abuse and report it should they suspect abuse had occurred.

Systems to assess and manage any risks to people's safety and well-being were not consistently used, acted upon and reviewed. For example, one person tried to

Summary of findings

climb over bedrails on their bed. There had been no risk assessment prior to their use and no review when this event occurred to try to prevent further incidents. Other people had been identified as at risk of malnutrition but no action had been taken.

Staff were not always recruited safely to make sure they were suitable to work with vulnerable people and staffing levels in the home did not always ensure that there were staff on duty with suitable qualifications, skills and experience.

People's medicines were not managed safely. Medicines were not stored, administered and recorded safely. Staff did not have clear instructions about the administration of some medicines such as pain relief. This put people at risk of harm.

Systems for ensuring the cleanliness of the home and prevention and control of infection were poor. Areas of the home such as kitchen, lounge, bathrooms and bedrooms had not been cleaned thoroughly. We found that items of furniture such as tables, armchairs and bedside cabinets were dusty or soiled. Equipment including hoists and commodes were not clean. Many areas required maintenance to ensure that surfaces were non porous and could be properly cleaned. The laundry area did not have separate areas for clean and dirty items.

Staff were caring and treated people kindly, with dignity and respect. We mostly saw good interactions between staff and people living in the home. However, we also heard inappropriate conversations in front of people and observed that when staff interacted with people it was mostly whilst specific task based activities were taking place.

Staff did not have the right skills and knowledge to provide personalised care for people living with dementia. This was because they did not have up to date, comprehensive training or regular support and development sessions with their manager. There were no systems to review staff competency and identify training needs. For example, some people were no longer able to communicate verbally. There was no evidence that staff had been shown other ways to enable communication or how to provide personalised care for people who had specialist needs such as epilepsy and diabetes.

There was little organised activity in the home. People's need for meaningful activity, occupation and stimulation had not been met.

It was evident that, despite undertaking training, staff did not fully understand the Mental Capacity Act 2005, how to assess people's capacity to make specific decisions or about those people who were being restricted under Deprivation of Liberty Safeguards. This meant that some people may not have been given the opportunity to make decisions about themselves and others may have been unlawfully deprived of their liberty.

People's care and monitoring records were not reviewed and maintained and were lacking in detail. This meant that they did not accurately reflect the care and support that they needed and put people at risk of not receiving appropriate care.

The design and layout of the home had not been adapted to reflect best practice guidance about how to meet the needs of people living with dementia. For example, the use of special signs had not been introduced and doors had not been painted in different colours to help people orientate themselves around the building.

The systems and culture of the home did not ensure that the service was well-led. This was because people were not encouraged to be involved in the home and they were not regularly consulted. The quality assurance systems in the home did not ensure that people received a good service and did not identify any of the shortfalls found at this inspection.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

Safeguarding procedures were not always followed which put people at risk of harm.

Care was not always planned and delivered in a way which protected people from the risk of harm.

Systems for the management of medicines were unsafe and did not protect people.

Staff were not always recruited safely to make sure they were suitable to work with older people.

Is the service effective?

Inadequate 

The service was not effective

Staff did not have the right skills and knowledge, training and support to care for people safely and using best practice methods

People's rights were not protected because staff did not understand the implications of the Mental Capacity Act 2005.

The design and décor of the home did not always take into account people's differing needs. For example, to assist with people's orientation around the home.

Is the service caring?

Requires Improvement 

The staff were caring and kind and people were positive about the care they received.

We found that care practices, such as the care of people with dementia, did not reflect best practice. For example, people's life histories and previous hobbies were not recorded and used when providing care and support and there was no recognition that people living with dementia should be involved and consulted about decisions affecting them.

Is the service responsive?

Inadequate 

The service was not responsive.

People's need to be kept occupied and stimulated was not consistently met. Very little information had been obtained about people's likes, dislikes and interests. Consequently people were not supported to pursue activities and interests that were important to them.

Summary of findings

People needs were not reassessed when these had changed and their care plans did not include sufficient information about their care and support needs. This meant staff did not have up to date information to tell them about people's individual needs and how to provide personalised care.

Information about complaints was displayed and people knew how to make a complaint. People and their relatives knew how to complain or raise a concern at the home.

Is the service well-led?

Inadequate 

The service was not well led.

Systems for checking and monitoring the service were poor. This meant shortcomings in the home and the service people received were not always identified and responded to promptly.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained

Sandringham 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 checked whether the provider was 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 10, 11 and 19 December 2014 and was unannounced. There was an inspector and a specialist advisor in the inspection team. We spoke with and met seven people living in the home and three relatives. Because some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We reviewed the information about the service along with other information we held about the home which included notifications they service is required to make. We also contacted one commissioner and three health care professionals involved with people to obtain their views.

We looked at four people's care and support records, an additional two people's care monitoring records, medication administration records and documents about how the service was managed. This included staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Inadequate

Is the service safe?

Our findings

The relatives and staff that we spoke with said that there were enough staff. One person told us, "This is the nicest, most homely home you could wish for, the staff are wonderful, kind and caring." Other people we spoke with told us that they always found the staff to be kind and caring and were happy that their relatives were being looked after.

Appropriate steps had not been taken to identify, assess and manage risk. There were no risk assessments for those people who had bedrails fitted to their beds. We found records that one person had attempted to climb over the bed rails to get out of bed. The records stated they had been agitated and at times exhibited behaviour that was challenging to others. There was no risk assessment for the fitting of bed rails, review of bed rails following the attempt to climb over them or any record of how staff should support them when they displayed challenging behaviour.

Another person was in bed and their bed rail did not fit the whole bed. This left a space at the head of the bed which could have allowed their head or other limbs to become trapped. We spoke to the nurse about this who told us, "That is why we put lots of pillows there and they (the person in bed), does not move so it would not be a hazard".

Staff had undertaken risk assessments with regard to the risk of people becoming malnourished. However, these lacked detail and had not been reviewed regularly. Four people had sustained considerable unplanned weight loss. A further person had also lost a considerable amount of weight before they died. The losses had been recorded and in some cases the risk level had been reviewed and noted to have increased but there was no evidence that relevant health professionals such as a GP or dietician had been consulted.

There were no emergency plans in place for the home. The provider confirmed that they were aware of the requirement to have one but had not yet developed one.

These shortfalls were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have systems to identify, assess and manage risks relating to people's health, welfare and safety.

The registered nurses and two senior carers had undertaken training to administer medication. One staff member had last undertaken training in 2010, six staff members in 2012 and two staff members in 2013. The training consisted of staff watching a DVD. Staff each had a certificate to confirm they had followed the DVD but this did not state what the training had included nor for how long the certificate was valid. A competency assessment had been carried out to ensure that one of the senior care workers was safe to administer medication in May 2013. This person had also undertaken medication awareness training with an external trainer in May 2013. The registered nurses had carried out an assessment of each other's competency to administer medicines in 2012. In some cases, notes had been made that further training was required but there was no evidence that this had been undertaken. Current guidance states that staff who administer medication should have their competency checked annually.

The medication policy did not reflect national and local published guidance about how to ensure medicines are handled, stored and administered safely. The policy did not include information about reviewing medicines, ordering, receiving and checking medicines, staff training and competency and auditing. The policy was not dated to evidence that it was reviewed and amended to reflect new guidance.

When we arrived on the first day of the inspection we found that the medicines trolley had been left unlocked in a communal area of the home. When we asked the staff about this they told us, "we don't need it here, there is always someone around". We explained that the trolley must always be locked and properly secured. There were two full boxes of painkillers left on the window sill in the office and the disposal bin for discontinued medicines was full and not properly secured which meant it would have been possible for these to be removed from the premises.

We looked at the controlled drugs register. An incorrect entry had been made in the record which meant that it appeared that a considerable quantity of a controlled drug was unaccounted for. The record had been signed by the person who wrote it and countersigned by another member of staff to confirm they had checked the record and it was correct. The record stated there were 9.75mls remaining in a 100ml bottle. Examination of the medication

showed that there were closer to 90mls remaining. We spoke with the nurse about this who told us "I wrote that, it is only that I put the decimal point in the wrong place. It is not as if there was less than the record."

One person required regular injections. We found that the registered manager had allowed one of the care staff to carry out this task. There was no record that the person had been given training or that their competency had been assessed to carry out this task safely.

Five people had been prescribed pain relief "as needed" (PRN). The were no care plans in place to advise staff when pain relief should be given, particularly if the person was unable to communicate their pain due to their dementia. The provider did have a pain assessment tool to help staff when assessing people's level of pain but this had not been used for over 12 months. One person had a pain assessment carried out in 2013 which stated that they were likely to shout if they were in pain and that the main things that caused pain was movement and personal care. The person was prescribed "as needed" paracetamol but records showed that this was rarely given. More than 12 months later a sedative medicine was prescribed because the person was shouting out, agitated and restless. There was no record that the person's pain had been assessed as a possible cause for their agitation and restlessness.

The provider had carried out a medicines audit in October 2014. It had not been fully completed and was not effective because it had not identified the shortfalls found at this inspection.

These shortfalls were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to the management of medication as people's medicines were not safely managed, stored, recorded and administered.

Training records showed that 14 of the 16 staff had undertaken training in infection prevention and control. One of the staff that had not undertaken training was the cleaner. The training consisted of staff watching a DVD. Staff each had a certificate to confirm they had followed the DVD but this did not state what the training had included nor for how long the certificate was valid.

Twelve staff had undertaken hand hygiene training in 2012. The provider carried out a hand hygiene audit in September 2014. This identified that some staff had long nails and were wearing nail polish. This can pose a potential risk as it is harder to properly clean your hands and this could spread infection as well as there being a risk of causing scratch injuries to people during moving and handling and personal care. No actions were identified on the audit. We noted that some staff had long nails and nail polish during the two days of our inspection.

We found various pieces of furniture and equipment were not clean, and were stained or damaged. This included damaged cushions on commodes, stained and broken bumpers to cover bed rails and arm chairs that had soiled arms and seats. In addition, over bed and chair tables had food debris and other marks. There was a stain on the seat of the sit on scales and a suction machine that had coloured fluid in the tubes which meant that it had not been cleaned since its last use. We also found various surfaces were dusty, especially in bedrooms. There was a bathroom and separate lavatory on both the ground floor and the first floor. All of these areas had damage to walls, tiles and wood work. A number of shelves and other surfaces in the kitchen were also damaged or worn .This meant that these areas were porous and could not be cleaned properly and therefore presented an infection risk. This had not been identified and acted upon by the provider or registered manager.

Both of the sluices were left open during the first and second day of the inspection. They contained cleaning chemicals and the ground floor sluice also contained a sharps bin. (These are bins that are used for the safe disposal of syringes). The bin was stained with dried blood splatters and, contrary to guidelines, was more than two thirds full and not dated when it was first used. This was a risk to people who could have access to the chemicals and open sharps bins.

The cleaner showed us record sheets with various items that were marked to be cleaned either daily, weekly or monthly. The records had not been consistently completed to show whether the areas had been cleaned.

Within the laundry there was no clear segregation of soiled laundry from the clean laundry and very little work space to sort items. We also found that the floor and walls were not sealed and easily cleanable. They presented an infection risk. We also found that the baskets used to transport laundry were dirty and stained.

Inadequate

Is the service safe?

The provider stated that they were the lead person for infection prevention and control in the home. They had last undertaken training in infection prevention and control in January 2011.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider had not taken steps to ensure that people were protected against identifiable risks from infections.

All of the staff had undertaken safeguarding training within the last four months. The training consisted of a DVD which staff had to watch. There was no evidence that staff's understanding and competency had been assessed following the DVD. We spoke with two staff who were able to describe the different types of abuse and confirmed that they would report any concerns to the person in charge.

The provider's policy and procedure regarding safeguarding stated that the home followed the local authority multi agency policy dated July 2011. There was no information about what the policy said or where it could be found. This meant that there was no easily accessible information for staff to follow if they should suspect that abuse had occurred.

We identified an incident that should have been reported as potential abuse in accordance with the local authority multi agency safeguarding policy. The provider and registered manager had failed to recognise this and make appropriate referrals to the local authority or to notify CQC. This meant that possible abuse had not been fully investigated and the staff concerned may not have been suitably checked and supervised.

The whistleblowing policy was detailed and informed staff of their rights and responsibilities. We found that not all of the agencies that staff could contact were listed. This meant that staff may not know who to report concerns to outside of the organisation.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to safeguarding people who use the service because appropriate information was not available for staff. The registered manager and provider had not taken appropriate action in response to a potentially abusive incident.

We asked the provider how staffing levels were calculated. The provider stated that a discussion was held between themselves and the registered manager. The usual pattern of staffing was one registered nurse on duty and two care staff from 8am to 8pm and one registered nurse and one member of care staff from 8pm to 8am. A cook was also employed for four hours a day and a cleaner for six days a week. This meant that care staff were responsible for preparing and serving breakfast and the evening meal and were also responsible for the laundry. We looked at previous, current and planned rotas. The provider confirmed that there had been a period of a few weeks when there was no registered nurse on duty. They stated that the registered manager lived nearby and had been "on call" when there was no registered nurse on the premises. This meant that there were people living in the home with needs that had been assessed as requiring trained nurse support but there was no one on duty to meet these needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to staffing because there were not sufficient staff with the right knowledge, experience, qualifications and skills to support people.

Most of the staff at Sandringham House had worked there for a long time. One care worker had been recruited since our last inspection and we checked this file. We found that the person had started work in the home without a full Disclosure and Barring Service check being received. The provider showed us that they had checked the list of adults barred from working with vulnerable people and that they had sent the forms off for the Disclosure and Barring check. However, there was no risk assessment and appropriate safeguards in place for the period the person was working without the full check.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people could not be sure that they are safe and have their health and welfare needs met by staff who have been subject to appropriate checks.

Inadequate

Is the service effective?

Our findings

There was a lack of up to date, evidence based knowledge about the care and support needs of frail older people, especially those with a cognitive impairment. This meant that people were not able to receive care, treatment and support that was based on the current guidelines and best practice.

People's relatives told us that they thought the food served in the home was good. We observed lunch being served during our inspection. It was nicely presented and foods were pureed individually for those people who needed it. Menus stated that a choice of meals was available. We did not see anyone being offered a choice and everyone was eating the same main course during both days of our inspection. We asked the cook if anyone in the home was at risk of malnutrition and if so, whether they fortified foods to help increase calorific intake. The cook told us that no one was at risk but that if they were, staff would request the person's GP to prescribe suitable supplements. We asked why one of the people in the home was having a pureed diet. The cook told us that was because the person's dentures did not fit. The provider later told us that the person refused to wear their dentures. We checked the person's care plan and could not find any information about whether the person chose to wear their dentures or any decision to give the person pureed food.

All of the people living in the home were weighed each month as part of a risk assessment to identify anyone at risk of malnutrition. Records showed that four of the nine people living in the home had unplanned weight loss resulting in them being at higher risk of malnutrition. There was no evidence that suitable support from a GP or dietician had been sought. Those staff that we spoke to about this indicated that they saw weight loss and lack of interest in food as part of the expected decline of a person living with dementia and that it was an indication that they may not live for much longer. In addition, one person with diabetes was very sleepy and unrousable during the first day of our inspection. We were told that they had been like this for four days and that they had therefore eaten very little. A visitor to this person told us that they had contacted the GP because they were concerned about their relative. None of the staff had identified this as a concern or considered whether the management of their diabetes should be reviewed.

These shortfalls were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people had not been protected from the risks of inadequate nutrition and hydration.

People's health care needs were not consistently met. Although people, relatives and doctors told us medical attention was sought promptly, this was not supported by some of the findings from the inspection. For example, there was little awareness that people with dementia may still be suffering from pain even if they are unable to verbally communicate this. We saw one person who was uncomfortable in their chair and frequently trying to readjust their position. When we asked about this we were told the person had a serious health condition and were likely to experience pain. However, there was no evidence that health professionals had been contacted to try to manage any pain or provide alternative seating which may have helped.

One visitor told us that their relative frequently suffered chest infections. They told us of an occasion where they were told by staff in the home early on in the day that their relative was ill but a health professional was not contacted until late at night. This resulted in their relative being admitted to hospital which they felt could have been avoided had staff contacted a GP as soon as they recognised the person was ill.

These shortfalls were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people's needs were not consistently assessed and reviewed and plans were not made to ensure that the care required was provided.

The provider and staff told us that none of the people in the home had the capacity to make any decisions for themselves. This meant that people were not involved in day to day decisions such as when to get up or go to bed, where to sit or what to do. There was also no consent gained from people before providing personal care, administering medication or any other decision which involved them. Six of the nine people living in the home were sharing bedrooms although there were other empty bedrooms in the home. There was no evidence that the people had made an active choice to share a room and no mental capacity assessment or best interest's decision to support a decision that two people should share a room.

Inadequate

Is the service effective?

The provider had not made suitable arrangements to act in accordance with the Mental Capacity Act 2005. Two members of staff told us that they had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training records confirmed that all staff had undertaken training via a DVD in August 2014 and should therefore have understood and implemented the requirements of the legislation. Where needed, people had not had their capacity assessed in relation to specific decisions so plans could be made and care could be provided in people's best interests. For example, everyone in the home was given a flu vaccination but there was no evidence that their capacity to make the decision had been assessed or that where they did not have capacity, the best interests decision making process had been used. The provider told us that some relatives had agreed to the vaccination but we found that they did not have the legal right to make this decision. This meant that people may be at risk of receiving care that they had not consented to, or that may not be in their best interest.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the home was not meeting the requirements of the Deprivation of Liberty Safeguards. The provider was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. However, the provider had not understood when an application should be submitted to the local authority and had therefore failed to submit applications although they accepted that there were people in the home who were being deprived of their liberty.

These shortfalls were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

Not all staff had received adequate supervision, appraisal and training to enable them to fulfil their roles effectively. The supervision policy for the service stated that supervisions would be carried out within the first week of employment and at intervals of three months or more frequently if required. It also stated that annual appraisals would be carried out. There was no plan for staff supervision to ensure that everyone received the required support. We looked at seven staff files. We found a record of one supervision session for one staff member and one annual appraisal for another member of staff in 2014. There were no recorded supervision sessions for the recently employed member of staff. This meant that there were no arrangements in place to facilitate the development of staff and ensure that they are able to undertaken their duties to a good standard.

There was no training plan in place to ensure that staff received regular updates. We found that most staff had undertaken refresher training in the essential areas that included moving and handling, safeguarding, infection control, and food hygiene. None of the staff had undertaken training in health and safety since May 2012 or first aid since August 2013. The provider was not able to tell us how long the training was valid for and therefore whether staff should have received refresher training in these areas. With the exception of moving and handling training, the training at Sandringham House consisted of staff watching a DVD. Staff each had a certificate to confirm they had followed the DVD but this did not state what the training had included nor for how long the certificate was valid. Moving and handling training was delivered as a practical course by the provider and a member of staff. The provider told us that they were qualified as a moving and handling trainer. However, there was no evidence, such as certificates, that they were qualified to deliver the training and for how long their qualification was valid. No competency assessments had been carried out to ensure that staff were able to support people to move safely.

All of the people in the home were living with dementia. We found that 11 of the 16 staff had undertaken dementia awareness training via a DVD in September 2012. This was a basic level training course. Discussions with staff revealed that they were not aware of recent changes in the management of dementia such as providing person centred care based on their personal histories, recognising the things people may be able to do for themselves to promote independence and encourage people to remain involved in making decisions.

Some of the people in the home had health needs such as epilepsy, diabetes, skin conditions and wounds. No specific training had been given to staff in any of these areas. Two staff had recently completed training in tissue viability.

Inadequate

Is the service effective?

There was no evidence that trained nursing staff and care staff had undertaken training to keep up to date with any changes in the treatment and management of other such conditions.

These shortfalls were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to the supervision, appraisal and training of staff to enable them to fulfil their roles effectively.

We looked at the design and adaptations in the home to see whether it met the individual needs of people living with dementia. We saw some signage in the home so people could identify and recognise toilets and bathrooms. In the ground floor lounge/dining area there was a wipe board with the date and day of the week on it as well as the menu for the day. However, the majority of décor was in neutral colours and for some people living with dementia they would not have been able to distinguish the differences between doors, furniture and walls. Not all people's bedroom doors had their name on it. There was nothing on bedroom doors to make it easier for each individual to recognise their bedroom.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to the safety and suitability of the premises because the premises have not been altered to meet their needs.

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke with were positive about the care provided by staff. One person told us, "This is the nicest, most homely home you could wish for, the staff are wonderful, kind and caring." Another person told us that they were always made welcome and found the staff to be very kind. However, their views did not reflect some of our observations and findings.

People were supported to maintain relationships with their families and friends. Staff and visitors told us that families were able to visit at any time and that staff were always welcoming.

Care files and other confidential information about people were kept in the main office. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

There were no care plans to record people's choices and wishes for when they reached the end of their life. Staff told us two of the people living in the home were receiving end of life care. There were no plans in place to ensure that their needs had been assessed and planned for and that medicines and equipment were in place. Training records showed that three staff had undertaken training in providing end of life care in January 2011 and fourth person had undertaken this training in July 2012. The service was not taking part in any accreditation scheme such as the Gold Standards Framework which is a set of standards for providing the best standard of care for people at the end of their life.

These shortfalls were a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not receiving the care, treatment and support they needed.

During our inspection we observed that staff were patient and kind whilst giving care but that the care and support they provided was focussed on tasks and timetables rather than on people's individual needs. The home had one lounge where people spent most of their day sitting in armchairs which were placed around the outside of the room and used as a way to divide the room into two sections. To reach the kitchen and office it was necessary to walk through the middle of the room. We saw staff walked through this room many times without acknowledging or engaging with the people sitting there.

Some people required support with eating and drinking. Some staff tried to talk with them and encourage them while other staff sat in silence or talked with other staff and visitors. We observed some staff calling people "love", "sweetie" and "darling" instead of people's names which did not respect people as individuals and could be confusing to a person with a cognitive impairment.

During lunch on the second day of the inspection we overheard a member of staff and a visitor discussing the recent death of a person who had lived in the home, other people who had died in the home, and the general decline of people with dementia. This took place in the lounge with seven people who were eating their lunch. There was no acknowledgement that some of the people may be distressed by such a discussion.

Staff did not hurry people and seemed to know people's likes and dislikes for things such as drinks and television programmes. However, people's life histories and personal preferences were not always recorded. This meant that not all staff may have been aware of people's preferences, likes and dislikes as there was no method to ensure knowledge gained by one member of staff was shared with all staff.

We observed that staff respected people's privacy and dignity. We observed that staff knocked on people's doors before entering and that doors were closed when people were assisted with personal care. We spoke with two members of staff to check their understanding of how they treated people with dignity and respect. They told us that they try to explain what they are doing and they always close doors or use screens when giving personal care.

People were not routinely consulted or involved in reviewing and developing their care plans after the initial assessment on their admission. Relatives had been involved in some people's initial assessments and had signed some people's care plans where people were not able to do this themselves. One relative had signed a care plan but they did not hold power of attorney for health and welfare and were therefore not authorised to consent to care on their behalf.

Requires Improvement

Is the service caring?

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not involved in making decisions about their care, treatment and support.

Inadequate

Is the service responsive?

Our findings

People had an assessment of their needs completed prior to moving into the home, from which a plan of care was developed. All of the care plans that we saw had not been updated as people's needs changed or were not in sufficient detail for staff to be able to follow them. Two staff told us they did not read people's care plans because they discussed people's needs in handover. Staff were able to describe the care that people required but this was not recorded. This meant that care plans did not contain sufficient information to enable new or agency staff to meet people's needs. This placed people at risk of not receiving the care and treatment they needed.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

People had needs that had not been assessed and planned for. For example, one person had been prescribed a medicine to be given in certain medical emergencies. There was no care plan to ensure that staff knew and understood the circumstances in which the medicine should be administered. Staff told us that one person had been diagnosed with a serious health condition and that they were showing signs that they were in discomfort or pain. There was no assessment or care plan related to this condition, the effect it would have on the person or the care that they required. Staff told us they could give the person paracetamol if they thought it was necessary. Another person was taking prescribed antibiotics for an infection. There was no assessment of the infection or care plan regarding the treatment and support of the person whilst they were unwell.

Pressure relieving mattresses and cushions had been provided for some people assessed to be at risk of developing pressure sores. We found that the settings for the mattresses had been determined from a list of people's weights in September 2014. We saw the record of people's weights in November 2014. The mattress settings had not been reviewed and changed following people's weight loss and this meant that the mattresses would not be working at an optimum level.

A number of people in the home were no longer able to communicate verbally. There were no care plans to advise staff on other forms of communication that may enable the person to indicate their wishes. Five of these people had been prescribed pain relief for various health conditions. There were no pain assessments or care plans to indicate the signals and signs that people may be experiencing pain and require medication. Another person had been bilingual. The progression of their dementia had meant that they no longer spoke English. Two of the staff told us that they were not aware of anyone else in the home who were able to speak their language. The provider later told us that there were two people in the home who had the ability to speak the language. We therefore could not be sure that all of the staff were able to communicate with the person or that they could make their needs known.

Care was not individualised. Seven of the nine people living in the home had been prescribed laxatives and enemas to relieve constipation. Staff that we spoke with all told us that it was important to administer these as it was often constipation which caused people to become more confused or agitated. There are wide differences between the frequency of people's bowel movements but care plans did not reflect this and there was a regime of administering laxatives and enemas within a very short period of time. Neither the laxative that was being used nor the enemas are now in common use. The treatment for constipation can include increasing dietary fibre through natural means such as fruit, vegetables and fluids. If this is unsuccessful bulking agents and softening products can be used. The use of laxatives and enemas can be uncomfortable and undignified. There was no guidance in care plans about how, if these were necessary, staff should ensure that they were administered in a compassionate manner and how staff should support people before, during and after the procedure.

Care plans were not person centred. They focussed on tasks which needed to be undertaken and there was little information around what people could do for themselves, how their independence could be promoted or how people may be assisted to make decisions for themselves or carry out tasks. The staff told us that all of the people were unable to undertake any tasks or decisions due to the level of their dementia. Good practice guidance recognises that everyone may still be able to participate at even basic levels and has the right to be supported in this.

Inadequate

Is the service responsive?

People did not receive support to meet their social needs. During the three days of our inspection, there were no activities organised for people to participate in. During the first day of our inspection there was either Christmas music or the television playing in the lounge which was where the majority of people spent their day. On the second day of the inspection we noted that everyone in the lounge had been provided with a magazine to read. Most people did not take any notice of these or seemed unaware of them. Staff told us that there was sometimes a visitor that provided hand massage. There were some assessments of people's past life history and hobbies in order to indicate activities that people may enjoy and participate in in the records for those people we looked at. The provider told us that some people's records did contain this information although we did not see any.

The provider told us that there was no planned programme of group activities because people were either not interested or not able to participate. They did tell us of one person who enjoyed a particular type of television programme and that staff therefore tried to ensure they were given the opportunity to watch such programmes. The provider told us that people responded well to one to one interactions with staff. The provider told us "these are usually unplanned as they can only take place when people are more alert". We did not see any records of activities that had taken place and how people had responded to them.

These shortfalls were a breach in Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not receiving the social stimulation, care, treatment and support they needed to meet their needs.

The provider told us no complaints had been received in the last 12 months. We examined the provider's complaints log which corroborated this. A copy of the complaints procedure was on display in the entrance hall. People we spoke with told us that they no complaints about the service they received.

Inadequate

Is the service well-led?

Our findings

The systems that were in place to monitor the quality of the service and identify shortfalls were inadequate. We found that the registered manager did not have scheduled time to manage the home and lead the staff.

The service had a registered manager. They were unavailable throughout our inspection. Analysis of the rota showed that the registered manager worked three 12 hour shifts per week. These shifts were as the only registered nurse on duty. They had no time allocated to the management of the home. The provider told us that they retained responsibility for some aspects of the management of the home such as the recruitment and supervision of staff, training, quality assurance and general administration which meant that the manager could concentrate on the day to day running of the home, care plans and reviews and rotas. The staff we spoke to were not always clear about the management structure and who took responsibility for which area.

We looked at the systems in place for monitoring the quality of the service that was provided. The provider told us that they undertook all quality assurance for the home. There were records of monthly checks of the cleanliness of the home, reviews of staff training and receipt of complaints. The record for the November 2014 and stated that the cleanliness of the home was "very good" and that staff training was "as per the matrix", it did not recognise that some training was overdue.

We found that other audits completed by the provider, such as care planning or the management of medicines, were ineffective because they had failed to identify or address any of the concerns we had identified during our inspection.

There were no records of staff meetings or any other consultation with staff. The provider told us that the home was too small to warrant staff meetings but that issues were discussed either during handover or informally during shifts. They stated that they were in the home frequently and felt that staff would raise issued with them if they were concerned. Staff confirmed with us that this was the case. However, from discussion with staff and the provider, there was no evidence of how learning from incidents, accidents, safeguarding, training or national and local developments were shared with staff and to improve the service.

The culture of the home was not open and inclusive. The provider told us that people living in the home were not able to share their views and contribute to the running of the service due to their dementia. The provider had consulted other people such as relatives and visiting health professionals by sending out a questionnaire in August 2014. This asked for people's views about various aspects of the home including the overall quality of care, staff attitude, cleanliness and complaints. A number of forms had been completed and returned. There had been no analysis of the forms and no action plan had been created in response to the answers on the forms. We looked at the forms and found that almost all were complimentary about the staff with comments such as, "Great caring staff" and, "They have dealt with a difficult situation very well". However, other comments included "slightly tired looking and small communal areas but otherwise clean and tidy. Staff cheerful" and, "Have noted there is very little stimulation for patients with TV droning on in the corner. Need music to stimulate memory. Tables in front of patients empty nothing for them to do or feel. Home decorated in the 80's, needs revamp. Very depressing and dreary." There was no evidence that any action had been taken in response to these comments. We discussed the condition of the home with the provider who agreed to give it some consideration. They told us that they had not been aware of the condition of some of the furnishings and furniture.

These shortfalls were a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider had not protected people from the risks of unsafe or inappropriate care through assessing and monitoring the quality of the service provided.

Notifications had been made to us for the majority of incidents. However, the registered manager and provider had not notified us of safeguarding allegations a required by the regulations. This meant that the provider had not shared information with us appropriately.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010 because the provider had not notified the Commission of incidents affecting people.

Some policies, such as the quality assurance policy, staff supervision and staff training were generic and had not been adapted to reflect the service being provided at

Inadequate

Is the service well-led?

Sandringham House. If staff relied on these policies they would not have had the correct information and this may have placed people at risk of not receiving the correct care and support.

Care plans and assessments were out of date, other records were incomplete or contained inaccuracies. These included cleaning records, audits and medicines records. There were no systems in place to ensure that records were being kept correctly.

These shortfalls were a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The provider did not respond appropriately to allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People did not always have access to premises that were of a suitable design and layout.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The registered person had not ensured that people were protected from the risks of unsafe or inappropriate care because they had not maintained accurate records.

Regulated activity	Regulation
	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: Appropriate checks were not undertaken before staff began work.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were not always sufficient numbers of suitably qualified, skilled and experienced staff on duty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or inappropriate care because staff had not received adequate training or supervision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider had not notified the Commission of incidents affecting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: People were not involved, so far as they are able to do so, in making decisions about their care, treatment and support.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: The provider had not taken proper steps to ensure each service user received was protected from the risk of inadequate nutrition or hydration.