Wraysbury House Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Wraysbury House on 27 October and 1 November 2017. The inspection was unannounced.

Wraysbury House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wraysbury House provides accommodation, nursing and personal care for up to 27 people in one adapted building. At the time of the inspection there were 24 people living in the home. People living at the home were older people with various support needs, including dementia, mental health and physical disabilities.

There was manager in post at the home who was currently in the process of applying to be a registered manager for the service. 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.

We last inspected the service on 26 April and 3 May 2016. At this inspection, we asked the provider to take action to make improvements as we found people were at risk of their care needs not being understood or met as their care planning records had not been fully completed, personalised and were not fit for purpose. We also found the provider had not ensured people's consent to care and treatment was sought in accordance with the Mental Capacity Act (MCA) 2005. The provider sent us an action plan on 31 July 2016 outlining how they would take action to address the matters.

Since the last inspection, the provider had been sold to another company in February 2017. The new owner of the provider had retained the same registration responsibilities as the previous ownership. These included ensuring that actions on the plan sent to us on 31 July 2016 had been completed. At this inspection we checked to see if the provider had made the necessary improvements in these areas. We found people were still at risk of not having their care needs met as the provider had not been able to ensure people's care planning records were fully completed, personalised or fit for purpose. We found the provider had taken adequate action to ensure people's care and consent was sought in accordance with the MCA. The manager and staff understood and put into practice the principles of the MCA when supporting people. People's care plans clearly documented that they or an appropriate person had consented to their care and this was open for review at any time.

The provider was not ensuring safe and proper management and practice when supporting people with medicines. Arrangements for managing medicines including obtaining, recording, storing, disposing and administering were not safe and people were at risk of harm due to this.

Identification, assessment and management of risks to people at the home was not always safe. We found that, although identified, there was a lack of detail and guidance in people's risk assessments and care plans about how to manage risks safely. Equipment in place to help manage risks to people was not always functioning.

Fire alarm checks and fire drills were taking place regularly along with health and safety checks and maintenance audits. However, there was no current fire risk assessment at the home so it was not certain the premises were safe from all fire risks and there was a lack of detail in people's personal emergency evacuation plans about how to support them safely in the event of a fire.

The provider had systems in place to audit quality and safety, but we found these systems were not effective. Identification of risks to people or areas in need of improvement was not consistent. Actions taken in response to any identified risks or improvements were not always implemented or successful.

The provider had not consistently followed safe recruitment practices. Records showed two references had not always been historically obtained for all staff before commencing their employment. The provider was now taking action to locate the missing references.

The home was not always clean and hygienic. On the first day of the inspection there were strong offensive smells of urine in the front entrance, hallway and from people's bedrooms. Areas of the property were not clean and furniture was stained and in poor condition. Housekeeping staff were under-recruited, leading to shortfalls in maintaining an acceptable standard of cleanliness. The provider had addressed these issues on the second day of the inspection.

People were involved in decisions about their care and relatives told us they felt the home provided kind and compassionate support. We observed staff supporting people in a caring manner. Staff we spoke to showed a good understanding of the importance of treating people with respect. However, during the inspection we found people's privacy and dignity was not always respected. We discussed this with the provider and they took immediate action to address this.

The home had enough staff to meet people's needs. The manager logged and reviewed accident and incident forms to help identify any themes and subsequent actions needed to keep people safe. Staff received safeguarding training and showed a good understanding of their responsibilities to keep people safe.

Staff received an induction that met the Care Certificate standards and received training in subjects relevant to their role. Some staff training was missing or required updating, there was a plan in place to address this and the provider was in the process of delivering this.

The manager was proactive in arranging and maintaining links with organisations to provide on-going guidance and training to help improve support at the home. Staff received regular supervisions and appraisals to support them to understand their responsibilities.

People had support to maintain good health and had access to healthcare professionals and services. Staff had a good understanding of people's health needs and monitored these appropriately. People had support to access sufficient food and drink and the home supported people to manage any dietary or nutritional needs. The service placed an emphasis on supporting a healthy, varied and balanced diet. Meal times were flexible and people had an active input in the menu and could choose what they wanted to eat.

The provider encouraged feedback and sharing information with people and their relatives in order to help them to respond to people's needs quickly and effectively. People and their relatives knew how to raise a complaint and felt confident to do so. People we spoke to who had raised a complaint were happy with the response they received.

The service supported people to access a range of social activities they could choose to take part in. There was an on-site activities co-ordinator and people had support to take part in activities in the local community. People had support to develop and maintain relationships with people important to them and had support to meet their cultural and spiritual needs.

There was a positive culture at the service and staff and relatives spoke highly of the manager. There was a good level of shared understanding from all staff at the home of the vision and values of delivering high quality care. Staff and management showed a willingness to work together to overcome challenges and concerns and develop the home to realise this vision. Staff felt supported and the provider was committed to supporting the manager and the team with any necessary resources to drive improvement at the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and that in some areas the service was failing to meet the national standards that people should be able to expect. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Management and use of medicines was not safe.

Identification of risks to people lacked formal guidance about how to manage these risks safely.

The premises were not clean and hygienic and some equipment required to meet people's needs was not functioning.

The home had not consistently followed safe recruitment practices. Some staff were missing required employment references.

The home had enough staff to meet people's needs. Staff received safeguarding training and showed understanding of their responsibilities to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff training had been accessed or renewed regularly.

Staff received an induction that met Care Certificate standards and had regular supervisions and appraisals.

People consented to their care and the service operated within the principles of the Mental Capacity Act.

People had support to maintain good health and had access to healthcare professionals and services.

People had sufficient food and drink and the home supported people to manage any dietary or nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring and had positive relationships with people but people's privacy and dignity was not always respected.

People were involved in decisions about their care and relatives told us they felt the home provided kind and compassionate support.

People had support to prepare for a comfortable, dignified and pain free death.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not fully completed and personalised and there was a risk not all of their needs were being met.

People and their relatives were involved in identifying how they wanted to be supported.

People had support to develop and maintain relationships with people important to them and had support to meet their cultural and spiritual needs.

People had access a range of social activities they could choose to take part in.

The home listened to and acted on concerns. People and their relatives knew how to raise a complaint and felt comfortable to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to audit quality and safety were not effective.

Identification of risks to people or areas in need of improvement was not consistent.

Actions taken in response to any identified risks or improvements were not always implemented or successful.

There was a positive and open culture at the service.

Staff and relatives spoke highly of management.

People, their relatives and staff were involved in improving and developing the service.

Wraysbury House Limited

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took into account information we received of potential concerns regarding unsafe medicines management and practice, people not being allowed a choice of when they got up in the mornings and a lack of suitably deployed and trained staff. This inspection examined those specific risks alongside the standard comprehensive inspection process.

The inspection took place on 27 October and 1 November 2017 and was unannounced. The inspection team for the visit on 27 October consisted of two inspectors, one specialist pharmacist inspector 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. For this inspection, the expert's experience included caring for older people and specialist mental health needs. For the visit on 1 November, the inspection team consisted of two inspectors.

We used information the old owner of the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law.

During the inspection, we met and spoke with people living at the service. We met with two relatives who were visiting the service and spoke with two on the telephone. We met with four support workers, the

assistant chef, the manager and the company director who was also the registered provider.

We 'pathway tracked' six of the people using the service. This is when we looked at people's care documentation in depth, and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care. Due to conditions of the majority of people living at the service, such as dementia, it was not always possible for us to hold conversations with them to gain their feedback. As this was the case, we observed care and we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we reviewed other records. These included four staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas and activity plans.

After the inspection, we asked the provider to send us copies of records relating to the management of the service and actions taken in response to issues identified for us to look at. The provider sent these to us in the five days following the inspection.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person told us, "It's good living here and the staff are very good." People's relatives said they felt people were "…safe and well looked after". Another relative told us their family member was "…well looked after - although he's had falls recently. His mobility is poor and he needs support but I think he's safe". We spoke to staff who were aware of how to record and report any concerns about people's safety. However, despite this feedback we found the service was not safe.

We had received information prior to the inspection regarding concerns that people were not receiving safe support with their medicines. During our inspection, we looked at the arrangements for managing medicines including obtaining, recording, storing, disposing and administering and found these systems were not safe.

People were not always receiving their medicines as intended. We saw people's prescribed creams given to other people, sharing of stock creams and use of stock belonging to people who no longer lived at the home. This meant people were at risk of receiving inappropriate treatment from non-prescribed creams and infection due to cross contamination from sharing creams. Homely remedies are medicines bought over-the-counter to treat minor ailments. We saw the home's stock of homely remedies was not all bought over-the-counter. Most of the homely medicines in use at the service had been prescribed for specific people, but staff had crossed people's names out and written 'homely remedy' on the labels. This meant these medicines were being shared and used by people they were not prescribed for.

There were not clear procedures for giving medicines covertly. Some people received their medicines covertly (disguised in food or drink). The home had not always assessed people's needs correctly to ensure medicines given covertly were in their best interest. Advice from a pharmacist had not been sought whether medicines could be crushed safely and mixed with food or drink. One person was prescribed a medicine that should not be given with milk containing products as it could reduce its effect. However, this was crushed and given in yoghurt. Staff crushed another medicine that was labelled 'swallow whole, do not chew or crush'. This meant the person may not receive the best outcome from their medicines.

The provider was not consistent in engaging with healthcare professionals to review people's medicines at appropriate intervals. For example, a person's MAR recorded them refusing two of their medicines; one for seven consecutive days and the other on five out of eight days. Staff had not taken action to contact the GP for advice. This meant the person's health was at risk of harm from not taking their prescribed medicines. During the medicines round we saw one person received their morning medicines at lunchtime. Staff explained the person was not usually awake for their morning medicines round. We observed staff giving another medicine to a person ninety minutes earlier than the time it was prescribed. However, for both people staff had not sought advice from the GP or pharmacist to know if this was safe. This meant the effects of the medicine may not alleviate the persons symptoms for the hours intended.

Staff did not record quantities of medicines received into the home and did not check stocks of medicines

against people's current list of prescribed medicines. For example, we saw medicines no longer prescribed for a person stored alongside their current medicines. The provider had not taken action to dispose of these appropriately. This meant the person could have been administered these in error and the home would not know if these medicines went missing. The provider did not have a process to check medicine expiry dates and dates when liquid medicines were opened were not always recorded. We saw expired medicines had been administered to people. This meant people were at risk of receiving medicines that were not safe to use.

We looked at Medicine Administration Records (MAR) for seven people for the past month. One person had not received two of their medicines on all days in the month; one was out of stock for three days and the other was stored in an upstairs store room and had not been administered for two days. The person was prescribed a liquid medicine to be given 'as directed', but there were no directions for staff to follow recorded in the person's notes. Some people were prescribed pain relief medicines on a 'when required' (PRN) basis if they need them. However, there was no guidance in place for staff to follow for any PRN medicines. This meant staff may not always know when to give PRN medicines or what signs a person might display if they needed them.

Medicines were stored securely in a locked trolley. However, medicines were stored in a conservatory. Heat can reduce the effectiveness of medicines. The conservatory was hot and there was no consistent monitoring of the room temperature. We checked service internal medication audit records regarding storage of medication and found that although temperatures were not being consistently recorded, there was clear evidence in line with our initial concerns that the conservatory was too hot and medicines were not being stored at the correct temperatures. For example, an audit note on 06.07.2017 recorded "advise strongly to move all trolleys and meds storage, currently kept in conservatory above 25 degrees Celsius". The medicines had not been moved from the conservatory. This meant the home could not be assured medicines were safe to use.

A medicines fridge was in use to store medicines that required cold storage. Staff showed us paper books where the medicine fridge temperatures were recorded. There were no guidelines in these books for maximum and minimum temperatures in place. The manager subsequently explained there was an electronic system for recording fridge temperatures, and this alerted staff to the correct temperature ranges. However, staff did not tell us they used this system or offer to show us this when we spoke with them about storing medicines in the fridge at the correct temperature. This inconsistency meant we were not able to see evidence that fridge temperatures had remained in a safe range consistently and medicines were safe to use.

Appropriate recording of people receiving medicines did not always take place. MARs had not always been signed by staff after medicines were given and staff did not keep records when applying creams to people. This meant the service could not be sure people had received their prescribed creams and other medicines at the times they were prescribed to be given.

We observed staff handling and administering medicines in a hygienic and caring manner and staff had received medicine training. However, the issues we found with medicines made it clear their training had not been effective and when we talked with staff, they could not demonstrate they always knew about how to manage medicines safely.

Due to the seriousness of the errors discovered on the first day of the inspection, the pharmacist inspector gave the provider and manager a list of direct advisory actions to put into immediate and on-going effect to keep people safe. We received assurances this would be done. When we returned for the second day of the

inspection, we saw the completion of all immediate actions as advised by the pharmacist inspector. We received further updates in the week following the inspection confirming the completion and arrangement of the remaining on-going actions.

We looked at the identification, assessment and management of risk to people using the service. We found that although identified, there was a lack of detail and guidance in people's risk assessments and care plans about how to manage risks safely. For example, people assessed as being at high risk of falls and requiring assistance did not have corresponding clear directions for staff to follow. One person's care plan stated they required support 'from a trained staff member during transfers (including) sitting to standing', but did not give any further detail about which techniques to use. We observed a staff member using unsafe techniques when supporting this person from sitting to standing .We checked and saw the staff member had not received manual handling training. Another person's care plan lacked detail about the support required to manage the risks associated with their eating and drinking. We observed the person asleep in a chair in the entrance hall of the home being woken up and handed a hot drink by staff, who then left. Without support, the person fell asleep again, spilling the drink on their clothes and remained this way for some time before staff became aware of what had happened and supported the person to change their clothes. In both of these examples, people faced an unacceptable and avoidable risk of harm.

We raised these issues with the manager at the end of the first day of the inspection and advised they take immediate action to ensure people's safety. When we returned on the second day of inspection there were updates to people's care plans advising how to manage these risks safely, manual handling training had been delivered for staff and the manager had alerted the resident's relatives and the local authority to the incidents that had occurred.

Equipment in place to help manage risks to people was not always functioning. People at high risk of falls had sensor mats in their rooms to alert staff they were attempting to walk and required support. Although necessary to keep people safe, there was no detail about the use of sensor mats in risk assessments and there was no guidance for staff about how these should be operated. We observed one person sat on their bed with feet on the sensor mat but no alarm sounded. We asked staff about this who confirmed this mat was not working. We checked and found that several sensor mats were not working, meaning staff had no way of knowing if people at risk of falls when in their rooms required support. This meant people were potentially not able to remain safe.

We raised these issues with the manager at the end of the first day of the inspection and advised they take immediate action to ensure people's safety. When we returned on the second day of inspection the provider had purchased new sensor mats, a daily check was taking place and a regular management audit of the checks was occurring to ensure the equipment was working.

We looked at whether the premises were safe. Staff completed regular health and safety checks. The manager carried out maintenance audits of the physical environment to identify issues. Fire alarm checks and fire drills were taking place regularly and had identified issues such as 'confusion over evacuation procedure' but it was not clear of actions taken in response to ensure people's safety. There was no current fire risk assessment at the home so it was not certain the premises were safe from all fire risks.

We checked to see if there were sufficient emergency plans in place at the home. We found a lack of detail in people's personal emergency evacuation plans (PEEP). This meant staff may not always be clear about what action to take to support people safely in the event of a fire or other emergency requiring them to evacuate the building. For example, people could not use the lift in the event of fire. Some people on the first and second floors could not use stairs and needed specialist equipment to descend safely if needing to evacuate

the building. Although equipment was in place, the detail about how and when staff should support people to use this was not in people's evacuation plans.

We raised these issues with the manager at the end of the second day of the inspection and advised they take immediate action to ensure people's safety, including contacting the fire service for advice. In the week following the inspection the manager advised they had contacted the fire service, updates were in progress for people's emergency evacuation plans and they had carried out a fire risk assessment of the home.

Despite these actions, due to the protracted amount of time all of the above issues, including failures to ensure medicines are managed, recorded, received, stored, disposed of and administered safely and failures to do all that is reasonably practical to mitigate risks to people is a breach of Regulation 12 - Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if safe recruitment practices were taking place. All staff had to complete an application form, provide two satisfactory references, pass a competency-based interview and have a comprehensive check from the Disclosure and Barring Service (DBS) to confirm their suitability for their role. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Records showed two references had not always been historically obtained for all staff before commencing their employment. This meant the service had not consistently followed safe recruitment practices.

We discussed this with the manager and provider who told us they were aware of this. The provider told us they had taken over the home in February 2017 and had identified these gaps for staff recruited by the previous provider but had not yet taken action to collect the missing references. The provider confirmed in the week following the inspection this action was underway.

When we visited on 27 October the home was not clean and hygienic. There were strong offensive smells of urine in the front entrance, hallway and in people's bedrooms. We observed leftover food down the side of a person's chair. There were stains on other armchairs and two communal sofas and one of the sofas was missing a seat cushion. The communal areas was not clean, the lounge floor was thick with dust behind the seats. The conservatory blind was missing slats and was dirty. The conservatory windows were unclean. On the first day of inspection, we did not see any domestic staff evident in the home and did not observe cleaning of communal areas by any other staff.

We brought the risk of infection from an unclean environment and the apparent lack of prevention and control measures in place in this respect to the attention of the manager and provider on the first day of inspection. The manager told us the current housekeeper was away on holiday and they had not arranged any cover. The manager took immediate action and when we returned for the second day of the inspection, there had been a complete deep clean of the house and the offensive odours were no longer present. The service had recruited additional housekeeping staff to ensure there would be cover in the future and the manager was auditing the physical environment weekly. The provider was also moving forward plans for refurbishment and re-decoration of the communal areas.

Prior to this inspection, we had shared intelligence with the local authority about the concerns being raised of potential unsafe practice at the service. Following our inspection we shared our preliminary findings regarding unsafe practice reported in this domain as an active safeguarding concern. The council confirmed receipt of this safeguarding alert and advised they would take action under their own authority to ensure people's on-going safety at the service.

Staff and seniors on shift completed accident and incident forms and recorded daily notes that also detailed any concerns about people's safety. The manager logged and reviewed accident and incident forms to help identify any themes and subsequent actions needed to keep people safe. For example, logs showed one person had recently been falling a lot. The manager had referred the person to a GP who had diagnosed a re-occurring infection as a probable cause for the high volume of falls. The GP prescribed medicine and the home had put in place one to one support until the person was more stable, along with a further referral for healthcare input to help manage the suspected cause of the infection re-occurring. Other people experiencing frequent falls had support to make referrals to physiotherapists, who had assigned walking aids to help minimise the risk of them falling.

Staff received safeguarding training and showed an understanding of their responsibilities to keep people safe if they were concerned they might be at risk of abuse when we spoke to them. A senior member of staff told us if concerned about a colleagues conduct, they would send the staff member home, reassure the resident, inform families and "I would go to the management". The staff member added they would also inform the Care Quality Commission (CQC), police and social services as they might need to be made aware. Another staff member told us they would talk to the manager if concerned about anyone's safety and "would expect the manager to raise a safeguarding and make the relevant arrangements". The staff member also told us they "could talk to other seniors" if they did not have confidence the manager would act on any concerns. Another staff member told us "we have a duty of care to people" and they were vigilant in raising any concerns. We saw records showing examples where the manager had informed the local authorities and the CQC about people being at risk of harm in response to concerns raised and agreeing what actions they were taking because of these.

People told us there were enough staff to meet people's needs. A relative said, "I'm happy that they look after him well." A staff member told us there was "enough staffing to meet people's needs" and if short staffed the service would always employ agency staff to fill any gaps on the rota. We sampled the service rota and discussed this with the manager, who had designed the rota utilising information from their care plan assessments and an electronic dependency tool to deploy enough staff to meet people's needs. There was an allocation sheet completed by senior staff during handovers at the beginning of each shift. The senior staff then used this as a tool to help delegate support between staff. This prevented people from not receiving care when they needed it and allowed delegated staff with the required skills to focus on certain tasks or people requiring specific support. We observed there to be enough staff on shift to meet people's needs during both days of our inspection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in line with their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection on the 26 April and 3 May 2016 we had found the provider had not always ensured people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005 and was therefore in breach Regulation 11 – Need for Consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had sent us an action plan detailing what actions they would take to meet the requirements of the regulation. We checked at this inspection whether the service was now working within the principles of the MCA and found that it was. We checked to see whether any conditions on authorisations to deprive a person of their liberty were being met and found they were.

Staff had received training in MCA and DoLS and understood how to put the principles of the Act into practice. One staff member told us, "Everyone has capacity unless assessed otherwise and has the right to do what they want if they have capacity, even if it's a bad decision". We were told by staff if they had concerns over someone's capacity they would "speak to the manager and have a best interest meeting", adding that it might be the case that a person's capacity may only be temporarily affected "for example if someone had a urinary tract infection". Another staff member told us that even if a person lacked capacity in some areas, "they can still tell you what they like". Another staff member told us it was very important to ask people for consent and "encourage, but not make" people accept any support offered.

People's care plans contained a clear assessment of their capacity in line with MCA legislation. Care plans recorded where a request for a DoLS had been submitted, what activities the DoLS applied to and on what grounds the request was being made. There was detail of consultation with any relevant third parties such as GPs, power of attorneys, local authority care management and family members to support applications of people's DoLS. The manager had submitted notifications to the CQC in line with legal requirements to inform us of approved DoLS in place for people at the home. People's care plans documented they or an appropriate person had consented to their care and treatment and this was open for review at any time.

Staff received a thorough induction that met Care Certificate standards. Staff received on-going training in subjects relevant to their role such as first aid, fire safety, infection control, dignity and respect, dementia care, challenging behaviour, health and safety, food hygiene, safeguarding, manual handling and medication. The home operated a system whereby staff completed training in two stages. The first stage

involved completing on-line training and the second stage involved attending face to face taught courses.

We checked and saw not all staff had received their training and not all staff training was up to date in line with the provider's own timescales for delivery and renewal. This placed people at increased risk of harm via poor practice from staff without the necessary skills or knowledge to carry out their roles. A relative told us, "The new staff still need training, the manager is still getting to grips with them - it's early days". One staff member had been at the home for a month but had not completed any training, saying; "I don't know when I'm having the rest of my training, I can't access the internet at home". Another staff member who had been at the service for a year told us although they had completed on-line training; they had "not yet done any face to face (courses)".

We discussed the shortfalls in people's training with the manager and provider. They were aware and acknowledged there was a backlog of staff training not completed or renewed in line with their policy. We discussed how the risk of poor practice was increased due to staff not having support to regularly access up to date knowledge relevant to their roles. For example, the risk of unsafe medicines management could be mitigated by ensuring staff had medicines training reviewed at regular interviews. This risk was acknowledged and it was explained this was a situation they had inherited from the previous manager and provider and they were in the process of taking necessary action to address the situation. We saw there was a plan in place to address the shortfalls in staff training and there were bookings made for upcoming training sessions to ensure all staff training was up to date in the next few months. The manager had recently completed the necessary qualification to be able to train staff themselves and would be able to deliver training on-site on a more flexible ad hoc basis in future.

The manager was proactive in arranging and maintaining links with organisations to provide on-going guidance and training to help improve support at the home. Community Dementia Matrons now regularly visited the home and provided training and advice specifically regarding supporting people with dementia and medicine. The registered manager was a member of the Worthing Dementia Alliance and a Dementia Champion with the Alzheimer's society. These links provided them with on-going best practice knowledge they were then able to share with their team. Staff found these initiatives beneficial and supportive and told us it helped to know "we can always ask for more training if we need it" if they felt they needed more support to be able to deliver an aspect of their roles confidently. A relative told us they could see a difference in the support being provided saying, "There's been lots of changes of staff and management (recently) but the staff training has improved".

Staff received regular supervision and had revived an appraisal from the previous registered manager within the last year. Staff told us they met regularly with the current manager and other seniors to discuss their practice and any issues in the home. There was an on-call system in place 24 hours a day, seven days a week where staff could ring a senior staff member or the manager at any time for support. The manager told us they used supervisions with staff to "support them to understand their role" and as an opportunity to review and set objectives for staff to help improve their practice. The manager also carried out spot checks and told us they regularly "worked on the floor" to be able to support the staff. We saw records of supervisions and spot checks that had taken place, including late night checks of the waking night staff. Supervision and spot check records included observations as to whether staff were capable or needed further training as well as setting objectives for staff to work towards.

People had support to access sufficient food and drink. Meals were evenly spaced and staff offered people regular snacks and drinks throughout the day. Meals were mainly served in the main dining room but people could choose to eat elsewhere if they liked. Meal times were flexible and people had a choice about what time they ate. People could request food and drink at any time during the day or night if they felt hungry or

thirsty.

The home supported people to manage any dietary or nutritional needs. The home carried out a Malnutrition Universal Screening Tool (MUST) for all residents. MUST is a five step process to identify adults who are malnourished, at risk of malnutrition, or obese and develop a care plan accordingly. People's care plans reflected their MUST assessment outcomes and people had an action plan in place to support them to manage any risks or maintain a healthy weight. Staff supported people to weigh themselves regularly and people's electronic care plans automatically recorded if a person's weight corresponded with their particular parameters for a healthy Body Mass Index (BMI). This allowed staff to take action if they saw people were in need of further nutritional support to maintain a healthy weight. There was a diet board in the kitchen that noted people who were diabetic and advised as to their specific dietary requirements. The diet board also contained information about healthy portion size and balance of food groups to help the chefs provide people with healthy and nutritious meals.

Requires Improvement

Is the service caring?

Our findings

People's relatives we spoke with said they thought staff at the home provided kind and compassionate support. One person said, "The regular staff that are there now are very good and they seem to care". Another told us "I think from what I have seen the staff are very caring". A staff member said they were committed to "treating people as my family or I would like to be treated". Another staff member told us they enjoyed their job as the approach of staff and management was "not as corporate" and "more homely, it does feel like a home".

We had received information prior to the inspection regarding concerns people were not being involved in decisions about their care and support. The information told us people were not given a choice when they got up each day and everyone routinely had support to get out of bed early in the morning. We checked and did not find any evidence this was the case.

We arrived on the first day of inspection at 07:35 and five people were up and in the main lounge. At 08:35 11 more people had either been supported to get up or had got up by themselves. 13 people were in their bedrooms and either receiving support to get up or doing this themselves and did not finish coming downstairs until more than an hour later. We asked staff when people got up and how early in the morning. One staff member told us people "start getting up at 6am or whenever they are ready". Another staff member said, "The night staff check on people around 6am to see if anyone needs continence support, it is up to the individual if they get up or not". The deputy manager told us, "It depends, the night staff do ask them before they leave whether they would like to get up, (people will usually get up) between 7am and 11am".

People's relatives told us they thought the home supported people to make decisions about their care and support, listened to and respected people's views. One relative said, "They let (my relative) be as independent as they can be". Staff told us they aimed to involve people as much as possible in their care and support and always looked to maintain people's independence. One staff member said "you should always let people do what they can do for themselves". Another staff member gave examples of ways in which they support people in this way, saying "We support people to keep walking if they are able and encourage them to choose their own clothes". The staff member explained this was important to maintain people's sense of identity so they could "keep hold of who they are". Staff told us of another example of how a person still chose to shave himself, although he needed full support with all of his other personal care needs, as he valued retaining this independence and staff respected that.

We looked at how the home respected and promoted people's privacy and dignity. On the morning of the first day of the inspection we observed a person's door had been left open and they were lying asleep half naked on the bed. When we checked later, the person's door was no longer open and when we entered their room, the person was covered with a duvet. We also observed several people left asleep in the entrance hall and lounge in undignified positions for several hours. One of the people in the entrance hall had become incontinent whilst asleep and was subsequently only supported by staff to visit the toilet and change her

clothes after several hours. The same person had ill-fitting dentures. We discussed these examples as highlighting the need for improvement to uphold people's dignity with the manager. The manager addressed this with staff and updated the person's care plan to reflect the need for more regular checks and a daily denture fix for this person. When we returned for the second day of the inspection we did not observe these issues.

Despite our findings on the first day of the inspection, staff we spoke to showed a good understanding of the theory and importance of treating people with respect and dignity. One staff member told us you had to respect people as individual adults, no matter what their support needs are adding, "Language is important, you ask someone if they need support with their pad not their nappy". Relatives confirmed the compassionate approach of staff saying, "My husband can't hold a conversation anymore it's all garbled but the staff sit with him and listen to him so he thinks he is having a conversation. That's a really kind thing to do I think". We observed staff being patient and kind with a person who had become incontinent in a communal area so the person maintained as much dignity as possible throughout a distressing situation.

Staff spoke to us about the importance of maintaining people's confidentiality saying, "You don't discuss people out of work or discuss things about people with other people at the home". Other staff members knew information about people needed to remain in the home and with the person. We observed the staff handover took place in an area out of earshot of people and staff discussed confidential information about people in an objective and factual manner.

The home developed positive and caring relationships with people. We observed people seemed to enjoy the staff's company and spending time chatting to them. The manager told us they encouraged staff to spend time getting to know people and they made sure they spent time with people alongside their managerial duties. The provider visited the home often and always made a point of meeting people to spend time talking to them informally. A relative told us, "I notice when the manager is walking around they never pass a resident without speaking to them". Another relative said, "(staff) want to help and get to know the residents". A staff member told us they "will always listen to people and talk to them". Another staff member told us they always felt they had time to sit and talk to people saying, "there's no rush". We saw staff using good techniques to make sure people understood they were listening to and including them, making sure they were at eye level, facing people directly and making eye contact when interacting with them.

The home showed concern for people's well-being in a caring and meaningful way. For example, we heard the deputy manager asking a person how their toothache was and updating them regularly to let them know they were contacting the dentist on their behalf. The activities co-ordinator enquired about people's welfare regularly and notified staff if people told them they needed something, so the person received what they wanted. We observed staff responding sensitively to people who appeared confused or disorientated, using appropriate touch whilst also speaking quietly and gently to reassure them.

People had support to prepare for a comfortable, dignified and pain free death. People's care plans clearly recorded their preferred last wishes and people also had an advance care plan in place. The advance care plan recorded advance decisions to be made prior to a person's death, preferred priorities for end of life care and this was regularly reviewed by the person and any other relevant persons such as relatives, advocates or those with lasting power of attorney for a person.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 26 April and 3 May 2016 we found the provider had not always ensured care and treatment of people was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 – Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan detailing what actions they would take to meet the requirements of the regulation. We checked at this inspection if the service was now providing person centred care and found there were still areas that required improvement.

We sampled people's care plans, which were identified in the last inspection report as lacking a breakdown of instructions and guidance for staff about how particular aspects of people's care was provided, in line with their personal preferences. The last inspection also reported a lack of evidence in people's plans that they had consented to their care, or they and their relatives had been routinely involved in the care planning process.

We found people's care plans still required improvement. In all plans we sampled we found the link between a person's life history and preferences and their individual support needs was not clear. All care plans we sampled included several exactly worded statements when explaining how to support people's dementia needs, but did not say why this support might be relevant or provide guidance on how best to provide it for the individual. For example, several people's care plan gave a direction to 'ensure they have at all times any memory aids they rely on' but did not say what these memory aids actually were, why they were important or how to support the person to access them. It was not clear from our observations, which people were in need of memory aids, if they had received support to access them if necessary and what the impact of this was if they needed them but did not have access to them. This meant people may not be receiving personalised care, their individual diversity may be misunderstood and their needs not met.

One person's plan included a generic direction, repeated in other people's plans we sampled, to encourage them to join in with others if attempting to do so. The same plan also detailed how the person's dementia had a 'severe impact on their ability to socialise' and this 'hindered communication between themselves and others'. The person's plan did not provide further instruction and guidance about how to encourage the person to participate with others safely. We observed this person repeatedly attempting to engage with other people and then receiving a light slap on their hand from another person who became distressed by the person's attempts to interact with them. Staff then intervened and successfully prevented the situation escalating. However, as a reactive response, the effectiveness in managing this person's needs was limited. When staff left, we observed other people becoming irritated with the person again. This was a running theme throughout the first day of the inspection. Without personalised preventative guidance for staff to follow, there was a risk to the person's safety and of them potentially becoming socially isolated.

Staff we spoke with gave mixed feedback about how person centred the care they delivered to people was. Staff said they knew how to meet people's basic needs but it would be beneficial to know people's personal histories to better understand and engage with people and improve their personalised care support. One

staff member said, "I don't know so well people's life histories and preferences. I know more about the tasks I need to do for each person". Another staff member said, "It's a busy day. Having time to read the care plans is difficult. I haven't read the care plans. I shadowed people and got to know the set way of supporting people". Other staff we spoke to said as well as asking other staff, they gained information from care plans to know how to meet people's individual needs. On another occasion we observed staff responding to people in an individualised way. Staff sang to one person who became anxious whilst holding hands, as a way to calm the person. This direction was included in the person's behavioural support plan and this appeared effective.

We discussed the possible risks to people not receiving effective personalised care due to the lack of consistent sufficient detail and guidance in their plans. The manager acknowledged this risk. We saw work was in progress on adding more detail and guidance about personalised care to people's plans. Although the service was taking action, there remains a risk that staff may not have the correct or most up to date knowledge or instruction about how to support people with their needs, as they would choose. Despite the action underway, the failure to ensure the care and treatment of people was fully appropriate, meet their needs or reflected their preferences is a breach of Regulation 9: Person-Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw recently re-written care plans evidencing the person and any relevant other people in their life, such as relatives or advocates, had been involved in the initial assessment of people's support needs and the writing of their care plan. Completed plans showed the home had taken into account people's strengths and levels of independence when assessing their needs. People had regular reviews via planned meetings or in response to changes in their needs when these arose. We saw an example of the service reviewing a person's level of independence after repeated falls and providing extra staff in response.

The manager told us they regularly met with relatives regarding people's care where this was appropriate and their input was actively encouraged. A relative told us, "We hold power of attorney and they always keep us fully informed of any changes…or any health problems (our relative) has". The home had recently introduced a new electronic care plan system to help update people's care plans immediately in response to planned or unplanned support reviews. We observed staff entering new information into the care plan system to note a person's support preference when a person declined to have full personal care support before breakfast, saying they would rather do this afterwards.

People were supported to access a range of social and cultural activities. An activities co-ordinator facilitated a range of group activities on-site during the week. Staff also supported people with individual activities as they chose. A relative told us, "There seems to be lots for them to do, they do dominos, ludo, singing, quizzes, colouring in, skittles and they have a gentlemen club too". We observed people enjoying individual and group activity sessions on both days of the inspection. People could put forward requests and ideas for different activities, such as theme nights where people could dress and eat food from particular cultures.

People had support to develop and maintain relationships with people important to them. Relatives were encouraged to visit at any time and many people regularly went out with their families. The manager had recently started to arrange group visits to a local community centre for people to be able to take part in activities with friends and peers outside of the home more frequently. A local vicar was starting to visit the home to deliver monthly sermons for people who were not able to attend church, in order to meet their spiritual needs.

People had information about their rights and how to make a complaint included in their care plans. Where

a person was not able to understand and access the complaints policy, the home provided their advocate or relative with a copy of the policy on their behalf. The manager told us they encouraged complaints as a way to help improve their practice. Relatives we spoke to felt comfortable to raise any issues and were happy with the way the manager had responded to any complaints. One relative said, "I would raise a complaint if I needed to but I think the care is good and they look after her well". Another relative who had raised an issue said, "I was listened to and the complaint was dealt with very quickly".

The manager told us they looked to encourage feedback and share information with people and their relatives to help them to respond to people's needs quickly and effectively. The home had recently started holding regular reviews with people and their families, recording actions to address any actual or potential issues, sharing the notes of the meetings and then providing an update at the next meeting. Relatives confirmed this approach had been positive saying, "If you have any problems the manager will act on it straight away" and it felt like the home was now "getting on top of things" for their relative.

The service had introduced CCTV to be able to monitor residents in communal areas. This had been installed in response to people becoming distressed and was used as a tool to help alert staff that people might need support if they were not physically present at the time. The CCTV was also installed to be used to help review instances where residents had fallen or left the building without staff being present to ascertain how the incidents had occurred and to help plan more accurately how to support people to prevent such incidents in future. We saw the provider had obtained consent from all residents, or relevant people acting in the resident's best interest, to install the CCTV.

Requires Improvement

Is the service well-led?

Our findings

The home had systems in place to audit the quality and safety of the service, but we found these systems were not effective.

Alongside supervisions, spot checks and staff meetings, the manager and senior staff carried out regular audits of the home and the care provided in areas such as medicines, maintenance and health and safety. The service had been sold in February 2017 and the new owner of the provider had recently introduced a new centralised on-line system, in which information from audits, staff supervisions and training records, staff and resident meeting minutes, care plan and risk assessment reviews, health information and people's daily notes was stored and updated. The system automatically alerted any safety or quality issues that needed addressing and created a plan with dates for actions to be completed.

The current manager had not been in post long prior to this inspection and told us they were not fully trained or confident in using the home's new electronic system to recognise and collate alerts and actions for improvement generated by the system. There were inconsistencies in the amount and frequency of data from quality audits and other records, such as training, staff files, meetings and people's care notes entered into the system. This meant it was not possible to gain an accurate oversight of service quality, identify and prioritise actions to address identified issues or generate a clear improvement plan.

Information we sampled from quality information and systems completed since the last inspection did not evidence consistent identification of risks to people or areas in need of improvement. For example, we sampled regular monthly medicine audits from the last year but there was consistent failure to recognise the many areas of unsafe and poor practice that we identified during this inspection.

Where audits and quality monitoring systems had been successful in identifying risks and areas for improvement, there was inconsistent and insufficient actions taken to rectify issues. For example, staff meeting minutes in October 2017 recorded an on-going issue of staff not plugging in sensor mats and this was a risk to people's safety. Action taken had not been sufficient and mats remained not working, putting people's safety at risk as we identified at this inspection Medicine audits in July 2017 had advised medicines be moved to ensure it was stored below 25 degree Centigrade as it was noted the medicine was being stored in a room consistently above this temperature, but no action had been taken.

By not maintaining quality assurance systems and evaluating and improving practice as necessary in respect of processing this information, the provider had not fulfilled their responsibilities regarding overall management of the regulated activity. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was committed to promoting a positive and open culture at the home. They told us they "value my staff and take time with them" and aimed to "lead by example" by working hard to support people, being approachable and being transparent. This approach meant staff and relatives had clear

updates about developments at the home and felt encouraged to engage in open communication about what was going on. One staff member said to us, "You can go to (the manager) with anything", adding this "makes it easier" for staff to do their jobs. Other staff told us "If you have got any problems you can speak to them". A relative told us, "I think all the staff are very approachable". Another relative said, "(the manager does not) hide away, (they are) always around in the building when I visit and they makes a point of coming to see me and tell me how things are going". We were also told, "I see the new manager every time I come in to the home, they always come and speak to me…I think they're very good and will sort things out." We saw team meeting minutes openly discussing issues at the service and encouraging staff to speak up and positively challenge poor practice with each other to help find solutions.

We discussed the vision and values of the home and the manager told us the home aimed to provide caring, person centred support of the highest standard. Recently employed staff told us these values were incorporated into their recruitment and induction processes. One staff member said a key value in the home was support needed to be "high quality" and that "you have to be caring at all times". Another staff member said a core value of the home was "to help people remain independent and have their own choices".

The manager was committed to actively involving people and their relatives in developing the service. The home had recently started regular residents' meetings and a suggestion box where people could give feedback about the home. Surveys were being prepared to help draw up a formal action plan based on people's feedback on what they thought could improve their experience of living at the home. Relatives' meetings took place to allow a forum for suggestions and to feedback on the progress of earlier actions based on these. A relative told us this made them feel included and that their input was valued, saying, "If there's any problem they listen and do their best to sort it out". Another relative said, "The new manager is excellent… She keeps me informed".

Staff told us they felt involved in helping to improve and develop the service. Regular staff meetings and supervisions kept staff up to date with any issues or developments at the service and encouraged their input in providing solutions to any issues. The manager took pride in maintaining a constant visible presence at all times, including working weekends and visiting night staff. Staff told us they felt supported by the manager and they delivered feedback in a positive and constructive manner. Staff told us (the manager's) "door was always open" and they were "very approachable".

Care homes and other health and social care services are required to notify the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check the action the service took and if necessary request additional information regarding about the event itself. The manager had submitted notifications to the CQC as required regarding all notifiable events that had occurred at the service. We saw examples where they had worked with external stakeholders such as the local authority and healthcare professionals in response to events to share information, agree and support each other to implement necessary actions.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service and on their website where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in a clearly visible way in the home entrance, along with a copy of the last inspection report, and displayed the ratings 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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014: Person-centred care. The provider has failed to ensure the care and treatment of people is fully appropriate, meets their needs and reflects their preferences 9 (1) (3) (b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to maintain quality assurance systems and evaluate and improve practice as necessary in respect of processing this information. 17 (1) (2) (a) (b) (f).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure medicines are managed, recorded, received, stored, disposed of and administered safely and failures to do all that is reasonably practical to mitigate risks to people 12 (1) (2) (a) (b) (c) (f) (g)

The enforcement action we took:

CQC have issued a formal warning notice to the provider, Wraysbury House Ltd. telling them that they must improve in the following areas by 31 January 2018; Regulation 12: Safe care and treatment
The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. CQC will return for an unannounced inspection in due course to check whether the required improvements have been made.