Life Style Care (2010) plc

Sandown Park Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Sandown Park Care Home is a care home with nursing that is based in a residential area of Windsor, Berkshire. The location is registered to provide care and support for up to 80 people. Sandown Park Care Home is located in a modern-built premises with three floors where people live. The building is surrounded by expansive gardens. The service provides care for older frail adults and people with dementia illnesses. At the time of the inspection the provider had applied to the Care Quality Commission to add an additional 15 beds to the service's registration. However the decision outcome from this separate process was not available on the days of our visit. Therefore this inspection report relates to the operation of the existing 80 beds of the registration only.

At the time of the inspection, there was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection was conducted on 8 July and 11 July 2014 under the 2010 Regulations. At the last inspection, we asked the provider to take action to make improvements to people's care and welfare, cleanliness and infection control, staffing numbers and staff training. The provider sent us an action plan on 16 December 2014. The current inspection occurred over two days on 19 November and 20 November 2015 and was unannounced. We consider that compliance has been obtained by the provider with regards to the previously breached regulations and that no further breaches are evident under the 2014 Regulations.

People we spoke with considered they were safe at the care home and did not express any concerns about their care. We found the service used a comprehensive nursing assessment and care planning philosophy which ensured that people's care was detailed and holistic. Staff we observed interacting with people were professional and ensured that risks were reduced as far as possible. There were sufficient staff to meet people's needs at all times, however the care home did not have a robust method of determining correct staff deployment. People's medicines were administered, stored and documented appropriately. Cleanliness and infection control systems had improved since the last inspection. We have made recommendations about determining staffing levels, infection control, building access for disabled people and fire and electrical safety.

Staff received extensive induction, training, supervision and performance appraisal for their roles. The service had embraced Skills for Care's 'Care Certificate' for new care assistants and there was evidence that staff had successfully completed the many components. The care home operated within the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Applications had been made to relevant local authorities when a person did not have mental capacity and had been under continuous supervision in the care home. Further applications for more people were in the process of being made. The service was not always abiding by the conditions of approved DoLS authorisations and the policies needed updating to ensure currency of information.

People were offered ample food and drink and the risk of people's malnutrition and dehydration were monitored. People also had good health outcomes as the care home ensured regular access to the multidisciplinary healthcare team from the community. One GP we spoke with was impressed with the standard of care that people received and the effectiveness of the management and staff team in caring for people.

We found staff were kind and generous. People's comments mirrored our observations from the inspection. One person we spoke with told us: "[I] could not wish to be in a better place". Another person we spoke with said: "I like it here. The staff have time for me". We saw that staff respected people's privacy and dignity, and ensured that life in the care home was as close as possible to living in the community. There was a large range of activities and events on a regular basis, and a sensory garden for enjoyment of touch, smell and sight for people with dementia. People were encouraged by staff to be involved in the buzz of the care home but we saw staff also respected people's right to spend time alone, for example listening to music or reading. People had regular opportunities to provide feedback to the care home and also have their say in how things operated.

Sandown Park Care Home participated in various types of research to make care even better. One research project focussed on medication which could help people diagnosed with Alzheimer's disease. Another study the home was involved in required staff to record daily observations of people's various health needs onto computer tablets. This information then created an ongoing quick glance look at people's needs, and also immediately flagged to managers any deterioration in health condition.

People had the ability to share their compliments, concerns and complaints in an open and transparent manner. Where feedback was provided by people or relatives, management would undertake necessary investigations and report back to the person who complained.

All of the people, relatives, staff and community teams we spoke with as part of the inspection commented that the home was well-led. They felt that the managers took time to listen and would take action to make improvements when needed. People felt that management were approachable and had a visible presence in the operation of the service. We found that the management conducted a range of audits to check on the standard of care. Where necessary, action plans were used to ensure that shortfalls were corrected. The service constantly searched for new ways to improve the quality of people's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Sufficient staff were deployed to provide people with prompt care. We made a recommendation about the service calculating safe levels of staff deployment.

The service was clean and had improved infection control mechanisms.

People were protected from avoidable harm like abuse or neglect.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training and supervision to ensure people's care was effective.

People's nutritional needs were thoroughly assessed and they were provided with sufficient food and drink.

Staff had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and people's care was mostly consistent with the codes of practice.

Is the service caring?

Outstanding

The service was caring.

People we spoke with told us staff and management were kind and compassionate.

People and their relatives were provided regular opportunities to express their views and be involved in making care-related decisions.

People's privacy and dignity were protected.

Is the service responsive?

Outstanding

The service was responsive.

People received personalised care that was responsive to their needs. We saw that people were involved in the planning and delivery of their care.

The service listened to people and relatives' feedback and acted on it to improve the quality of care. Concerns and complaints were investigated and responded to in order to ensure people's satisfaction with care.

The service participated in, and took note of results from social care research. This helped to improve people's quality of life.

Is the service well-led?

Good

The service was well-led.

The quality of care delivered to people was central to the operation of the care home. The location was involved in research and continually looked at how they could improve through audit and reflection.

The management team at Sandown Park Care Home were professional and approachable. People who used the service, relatives, staff and other external agencies were very positive about the home's management.

People's care was planned and delivered taking account of current guidance.

Sandown Park Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 November and 20 November 2015 and was unannounced.

The inspection team comprised a lead inspector and three specialist advisors. A specialist advisor is a professional who has expert knowledge in a particular subject. One specialist advisor was an infection prevention and control nurse, one specialist advisor was a best interest assessor and looked at the provider's compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and one specialist advisor checked building and maintenance safety.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and incidents and changes which the provider had informed us about. Prior to the time of the inspection a Provider Information Return (PIR) had been requested, and one was submitted by the service on 28 July 2015. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

In order to gain further information about the service, we spoke with12 people who used the service and 6 relatives or visitors. We also spoke with the registered manager, deputy manager, maintenance person and 17 other staff. Outside of the home we contacted the local authority, Clinical Commissioning Group (CCG), and two GPs. We also spoke with a project manager and a local authority best interest assessor who visited the service on the days of the inspection.

We looked throughout the care home and observed care practices and people's interactions with staff during the inspection. We reviewed 14 people's care records and the care they received. We looked at people's medication administration records (MARs). We reviewed records related to the running of the service such as five personnel files, staffing information, training records, documents associated with the equipment and premises and quality monitoring audits. We asked the provider to send us further

information about maintenance procedures after the inspection, which they did.

Observations, where they took place, were from general observations. Some people who lived in the care home were not able to tell us their own experience of care. We used other methods to determine these people's experiences of care.

Requires Improvement

Is the service safe?

Our findings

None of the people we spoke with had any concerns or complaints. People we spoke with told us they felt safe at the service. They told us if they felt something was wrong, they would not hesitate to report it to any staff member. When we spoke with staff about the steps they would take if this happened, they were able to explain their potential actions. They told us they would make sure people were safe, report any allegations of abuse to management and if needed contact external agencies, for instance the police or local authority. The six staff we asked were able to identify different forms of abuse and give examples of each type. Each staff member was asked to read the provider's whistleblowing policy prior to commencement of their role. New staff signed an acknowledgement form to demonstrate they understood the principles and this was stored in their personnel file. All of the staff we spoke with knew what whistleblowing was, and examples of when they may need to use it. The provider's policy for 'dealing with abuse' dated August 2013 was accessible to staff at all times. The local authority confirmed that the care home always reported any instances of alleged or actual abuse or neglect.

We looked at how the provider had ensured equality and diversity consideration in the building for people who use the service, relatives and staff. In accordance and compliance to the Equality Act 2010 and relevant British Standard, there was not clear provision provided for less able and disabled persons so they were not discriminated against on the grounds of their disability. Some areas within the premises are considered to require improvement in terms of safe access and use for persons who are less able and disabled. For example, appropriate sanitary fixtures and assemblies should be provided to ensure people with disabilities or in a wheelchair can safely access and use such facilities as able persons would. No provisions could be found that would be deemed acceptable in terms of management or operational of the facility. We found that many of the nurse call cords in people's en-suites and bathrooms were either tangled, tied to equipment or inappropriate in lengths. The main lift car did not have any form of voice activation to advise people what floor they were on or intending to alight or when doors would open or close, which was a risk to people in wheelchairs. A single disabled car parking bay was observed in the car park with the appropriate safety zones and markings. However, there was no sign fixed on a post or on a wall identifying the presence of this facility. There was also no availability of a suitable disability and an equality policy for review specific to this establishment.

We looked at how the provider managed risks to people arising from the premises and equipment that was used. We examined the service's fire risk assessment dated 29 September 2015 and saw it identified issues of 'significant findings' in accordance with the Regulatory Reform (Fire Safety) Order 2005. For example, it made no reference to how less able and disabled persons would be managed safely in an event if there was an evacuation to a point of safety. Thirty people were listed in the risk assessment to be wholly dependent and reliant on staff. Two emergency lights during inspection did not work or were very dimly lit when tested with a 'fish key'. This meant poor levels of lighting in an emergency situation, which was a risk for example to people with visual impairment or dementia. There was no clear labelling of emergency shut off points, no service identification, labelling or drawings of layouts within the plant room. These were required to ensure a clear and concise level of information for safe isolation of services and maintenance management. There was no fully loaded and clearly marked fire action or evacuation floor plans in accordance to relevant

guidance. Therefore all staff who managed and used the building could be unsure of the appropriate course of action in the event of evacuation should the fire alarm be activated continuously. No external fire signage could be found by inspectors nor recorded as a 'significant finding' within the fire risk assessment.

We looked at electrical safety across the service. A current and valid five year fixed wiring certificate was provided. We observed a number of concerns such as socket outlets less than a meter away from 'wet areas' which were not protected to avoid electrical shock. The maintenance person confirmed a number of alterations and additions had been made to the electrical system following construction, for which safety certification was provided. We found the staff member had been carrying out electrical work including wiring. This meant the staff member should have had the qualifications, skills and competencies of a qualified and registered electrician, but did not fulfil this requirement.

At the previous inspection on 8 July and 11 July 2014, the provider was found in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Staffing. An action plan was received from the provider on 16 December 2014. On this date, the previous set of regulations was in operation. Although the current inspection was under new regulations, we also looked at whether the provider had made improvements since the last inspection and their action plan.

We looked at six personnel files to check how new staff applicants were recruited and what documents were checked and recorded. Personnel files were kept on site at the location and contained all of the information required to ensure only fit and proper candidates were employed. We saw that interview answer notes were kept for each new employee interviewed, although they did not keep a record of the questions asked. Evaluation of the applicant's responses at interview provided a scoring system that determined whether the care home offered the job. Personnel files contained proof of identity, criminal history checks, employment history and conduct checks, and medical fitness information. We also checked compliance with right to work requirements set by the UK Visa and Immigration service. We saw the provider kept a continuous log of staff's right to work documentation by photocopying residence permits, passports and other entry clearances. We found none had expired and where expiry dates were close, the administrator had requested the employee to provide updated proof of their right to work. Where right to work documents had expired and the employee was unable to provide updated proof, the staff member was prevented from working. For 14 registered nurses, we saw the care home maintained a list Nursing and Midwifery Council (NMC) registrations and these were all current at the time of the inspection.

The care home previously suffered from an ongoing registered nurse recruitment and employment problem which had left vacancies for registered nurses. The registered manager conducted an analysis of why registered nurses could not be attracted to roles or commit to stay. After determining some more common reasons why nurses left, the manager implemented steps to encourage applicants to vacant roles and to continue their service. One decision the registered manager had approved by the provider was to increase the hourly wage rate in an effort to attract nurses. This saw registered nurses apply to work at Sandown Park Care Home and to stay on after their induction. At the time of the inspection, there were no nursing vacancies and also no use of agency staff. When we asked registered nurses and care assistants what happened if staff called in sick or could not attend a shift at short notice, they told us the deputy manager or registered manager would attend instead. This included evenings and on weekends.

During the inspection, we observed that people's call bells were answered promptly and that care was streamlined and not rushed. We asked the registered manager about the system the care home used to derive effective staffing numbers. Although no particular model was used to establish safe staffing levels, a 'staff build up' document detailed how many staff should be deployed depending on the total number of people living on each floor. For example, on the morning shift on the ground floor the document stated two

registered nurses were to work if there was more than 21 people living there. We saw this was in place at the time of the inspection. We also looked at rosters of staff attendance between 4 September 2015 and 29 October 2015 to check staffing levels. We saw that the nursing and care staff numbers on each shift of each floor matched the staff plan. Where absence of staff occurred due to annual leave, sick leave or requested changes, staff were rearranged to cover any shifts. People we spoke with provided positive comments about the number of staff which was reflected in meeting minutes also. However, the service did not use an assessment method that determined the safe level of staff to deploy for people's individual dependency.

People's medication management process in Sandown Park Care Home was safe. We saw that people's medication administration records (MAR) were accurately and fully completed and that there were no recorded gaps in medicines people were given. Medicines trolleys were appropriately secured away and controlled drugs were locked in safes. We saw they were always counted and administered by two staff, as required by law. Fridge and room temperatures were monitored and recorded, and we observed these were within the safe range. For 'as required' (PRN) medications, we found there were protocols drawn up which ensured that people did not receive excessive doses. We also observed part of a medication round with one of the registered nurses. We saw that they followed a practice process which ensured people received the correct medication at the correct time. The nurse also ensured people had swallowed their medicines before they left them.

We saw the medicines management policy from the provider dated January 2015 which covered the supply, storage, administration and disposal of medications. When we checked people's records, we saw they had photos attached to their MAR for identification purposes, that people who received 'as required' (PRN) medicines had current relevant protocols attached, and that covert medication administration followed best practice guidelines. We also checked insulin administration and recording for one person with diabetes. We saw that staff rotated body sites for administration, checked and recorded the blood glucose level and had information about what to do in a diabetic emergency. We found nursing staff had advanced knowledge of diseases and conditions and were able to ensure people's safety related to medication administration.

At the previous inspection on 8 July and 11 July 2014, the provider was found in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Cleanliness and infection control. An action plan was received from the provider on 16 December 2014. On this date, the previous set of regulations was in operation. Although the current inspection was under new regulations, we also looked at whether the provider had made improvements since the last inspection and their action plan.

The quality manager for the provider was the director of infection prevention and control for the company and responsible strategically for all infection control matters. The care home manager led all infection prevention and control at local level. We found there was an infection control policy dated February 2011 which outlined relevant infection control practice such as hand washing, protective clothing, and spillages of body fluids, managing sharps, managing and reporting outbreaks, and clinical waste and environmental cleaning. Risk assessments for infection prevention and control were carried out as part of individual care planning. For example we saw documents that took account of any concerns highlighted on transfer or admission such as people's susceptibility to infection or history of MRSA. We saw environmental risk assessments had been carried out and were next due for review in November 2016.

Quality audits including infection control practice were carried out on a quarterly basis by management and acted upon to ensure a safe environment for service users. Audits for January, April, July and October 2015 were reviewed and we found action plans had been drawn up and concerns identified addressed. We found staff undertook infection prevention and control training and had their competency assessed. Review of

records identified that staff on duty on the day of inspection had undertaken a competency assessment. Discussions with both care staff and the registered nurses confirmed that they had received training and that they were able to describe standard precautions in infection control.

The care home was observed to be clean including the assisted bathrooms, sluices, toilets and people's bedrooms. Ad hoc observation of toilet seats and personal equipment identified that they were also clean during the inspection. There was a housekeeper available on every floor. We noted the housekeeper had cleaning specifications and schedules which were kept on each of the floors in the nursing office. These schedules were signed by staff when work was completed and monitored by management who also signed once ad hoc checks had been carried out. There was a cleaning checklist for each person's bedroom. The cleaning specifications were basic and did not describe what materials or detergent to clean with or how to clean. Discussion with a housekeeper confirmed that they had a good understanding of their role and were able to describe the colour coding protocol for cleaning. They could also describe in what order they cleaned people's rooms and what detergent was used.

We found some areas where the care home needed to continue to improve their infection prevention and control processes. The hand wash basins were not in line with clinical hand wash basins. They were compact and difficult to thoroughly clean hands in effectively. However, staff had access to alcoholic gel and were able to describe what they did when attending to people's dressings. For example, how they washed their hands and practiced aseptic technique to avoid any transfer of infections. We found sharp boxes in all treatment rooms were not dated and signed when assembled or when sealed and disposed of. Spare sharp boxes were observed to be stored on the floor on the second floor treatment room. Sharp boxes were not assembled in accordance with the care home's own infection prevention and control guidance. Observation of the environment identified some concerns where the shower room, bathrooms and toilets on the ground floor had scratched and damaged walls. The manager explained that there was an ongoing plan of refurbishment within the home. There were two sluices on each floor which contained bed pan washers. Some sluice rooms were observed to be compact whilst the new sluices were bright and more spacious. The sluices contained laundry bags; white, red and blue to segregate the laundry. They had yellow waste bags for offensive waste and orange for clinical waste. Hand wash basins and PPE were available however hand wash basins not in line with current hand wash basin guidance. Extract ventilation did not appear to work in all of the rooms but the windows were opened to allow for air circulation.

Laundry was undertaken in house by two dedicated staff. There were some instructions inside the laundry regarding management, including what to do with soiled laundry and what programmes to put the washing machines on to ensure that soiled laundry reached the correct temperature. We saw these had been provided by the company who installed equipment and supplied detergents. These instructions were in three different languages, Lithuanian, Polish and Russian and the staff within the laundry were from Lithuania and Poland. There was however, no companywide guidance procedures available within the laundry regarding how to manage the laundry. The laundry assistant was able to explain what they did and how they trained the assistant. They were also able to explain their understanding of control of substances hazardous to health (COSHH) and the detergents they used.

We recommend that the service seek advice and guidance from a reputable source, about how the premises could better ensure provision of safe access for people with a physical disability.

We recommend that the service seek advice and guidance from a reputable source, about the management of potential fire and electrical risks in the building.

We recommend that the service develop a systematic approach to determine the number of staff and range

of skills required in order to meet the needs of people using the service and keep them safe at all times.

We recommend the service further consult the Department of Health's Health and Social Care Act 2008 'Code of practice on the prevention and control of infections and related guidance' dated July 2015.

Good

Is the service effective?

Our findings

At the previous inspection on 8 July and 11 July 2014, the provider was found in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Supporting workers. An action plan was received from the provider on 16 December 2014. On this date, the previous set of regulations was in operation. Although the current inspection was under new regulations, we also looked at whether the provider had made improvements since the last inspection and their action plan.

We saw staff at Sandown Park Care Home had attended comprehensive training to improve their knowledge and skills for delivery of care. We looked at the training matrix dated 20 November 2015. We could see that staff had undertaken training in a range of topics like fire safety, food hygiene, moving and handling, infection control and health and safety. The training log showed that very high percentages of staff had completed training or renewed their annual refresher of the various subjects. For example, 99 per cent of applicable staff had completed training in dementia awareness and control of substances hazardous to health (COSHH). Some staff had completed training in advanced clinical skills like collection of blood samples and insertion of urinary catheters. When staff were deemed competent in these skills, they were able to perform the task on site. This meant people did not have to wait for a GP or be transferred to a nearby healthcare establishment for the procedure to be undertaken. We also found that 71 staff had completed training in 2015 about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Standards (DoLS). This resulted in a high number of staff being able to react appropriately to ensure that where people did not have capacity, the right actions were taken to ensure people's best interests.

In 2015, Skills for Care replaced the Common Induction Standards with the Care Certificate and Sandown Park Care Home had implemented this for new care assistant induction. We looked at three examples for staff who had successfully recently completed the Care Certificate and spoke with the registered manager. We were told that in the first four days, staff undertook classroom-based training and were orientated to the requirements of the certificate. In this phase, new care assistants completed a self-assessment to record their beginning knowledge level and read the employee handbook and related policies. After this, staff shadowed a more experienced care assistant on the floor to observe practice, met people and started to learn working a full practical shift. As new workers increased in knowledge and experience, they completed the 15 'standards' of the certificate. We saw that a comprehensive detailed recording of teaching and competencies was maintained for each new starter. This showed staff completed the training properly in order to effectively carry out their roles and responsibilities. The registered manager told us that night shift workers were slower to complete the certificate, but usually finished the course within four months of commencement.

We looked at the structure for staff supervision meetings and performance appraisals. We saw that there was a clear structure in place for which staff members met on a regular basis with supervisors to review their performance and discuss any issues. We looked at the supervision calendar and saw that for all staff, they had participated in regular supervision sessions throughout 2015 and for the majority of staff this amounted to five or six sessions. We looked at an example of a staff member's completed supervision and noted that a detailed record of the meeting was kept, that concerns the staff member had were raised with the supervisor

and that both shared goals and learning. We saw the staff appraisals on a six-monthly and yearly basis occurred so that formal reviews of staff performance outside of supervision meetings could be reviewed and recorded. The provider's policy for staff appraisal was dated July 2011 and may require updating.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke to the registered manager specifically concerning the operation of DoLS at the care home. They told us that 12 standard authorisations had been granted by local authorities. A further 25 applications for standard authorisations had been submitted to the relevant local authorities. No applications for urgent authorisations had been made by the care home. The registered manager believed that a further 13 service users required a standard authorisation and they were progressively making the appropriate applications. We found the registered manager was very aware of the importance of the MCA and of the DoLS in particular.

We looked at the provider's DoLS procedure dated July 2012, Procedure for Assessing Mental Capacity dated January 2013 and Policy for Consent to Care and Treatment dated May 2015. After examination of the relevant procedures in the care home, we found that they needed to include better reference to the Supreme Court ruling from March 2014 regarding mental capacity and DoLS. We also found that the Procedure for Assessing Mental Capacity did not specifically refer to the importance of making and recording best interest decisions or cover the responsibilities of the independent mental capacity advocates (IMCA). In addition, the Policy for Consent to Care and Treatment did not refer to advance decisions to refuse treatment (ADRTs). We spoke to the registered manager about this and they told us they would take action to make changes related to our findings.

We spoke with three staff regarding their knowledge and practice for the MCA and DoLS. One registered nurse confirmed they had received training concerning mental capacity. They were aware of the five key principles of the Act but could only recall two at the time of the inspection. They told us they were not aware of the March 2014 Supreme Court ruling or the 'acid test' for determination of whether DoLS applications may be required. Another registered nurse told us they had received training concerning the MCA but they could not tell us about any of the five principles. They were also not aware of the Supreme Court judgement or the 'acid test'. We spoke to a care assistant regarding MCA and DoLS. They told us that they had received training concerning the Act and gave us examples of how they encouraged people to make choices, for example concerning their menu choices.

We looked at the care records of seven people who used the service for evidence specifically of how the care home followed the requirements of the MCA Code of Practice and the DoLS Code of Practice. We observed the care home used a form called 'Assessment of Capacity' and examined three of these forms. We found that none had been fully completed and the form did not state whether in the opinion of staff the person had capacity or not. It was not always clear as to the nature of the decision in respect of which capacity was being assessed. There was a section on the form for indicating whether a person had an 'EPA, LPA and a ADRT'. In each of the three forms we looked at this section was completed in the same way However, when

we cross-checked the information contained in this form with the information provided by the supervisory body in the standard DoLS authorisation we found inconsistencies. An example of this was the care home stated that a person had a lasting power of attorney (LPA) but the DoLS authorisation clearly recorded that no LPA exists.

DoLS authorisations were not kept on the care record but stored in an administration office. This meant staff were not readily aware of the conditions of the DoLS approvals because they could not readily view them. This was important because there was specific information in the authorisation documentation which the care home needed to be aware of. This included instances of conditions to the standard Authorisation like the details of the person's relevant representative and the existence of a deputy, ADRT or LPA. For one person, a condition was for the care home to "keep a behaviour chart to indicate the full degree, nature and duration and frequency of any episodes of challenging behaviour, screaming or shouting and the staff response to this". For another person, a condition of authorisation was for the "managing authority to complete behaviour charts to record the full degree and duration of any challenging or aggressive behaviour that [the person] should present and the staff response to this". We could not see any evidence on the respective case files that these conditions had been met by the care home. We discussed these instances with the registered nurse on the respective units and they could not evidence that this condition was being met.

People had positive comments about the food and drink. They told us they had plenty to eat and drink, and if they did not like the menu selection they were free to choose something else. We saw menus contained a large selection of choice, with at least two main meal options for lunch and dinner. The menus changed twice a year, with summer and winter variations. When we spoke with the chef about the menu, they had an excellent knowledge of people's preferences and needs. The chef also explained that people were able to have cooked breakfasts if they desired, cakes and pastries or fresh fruit, and rapid convenience meals if there was a need because of care requirements.

Dining rooms were seen to be tastefully decorated and fitted, and dining tables contained condiments and accessories which enhanced the dining experience for people. For people with special needs or food allergies, these were known by staff and care was adjusted accordingly. For example, some people required thickened fluids to decrease the risk of choking. We saw staff followed instructions and delivered continuity of care in making the fluids to the desired consistency with the required products. Staff were also knowledgeable about people who had fluid charts or nutrition logs in place. Three care assistants we spoke with were able to explain why a group of people had fluid intakes recorded. A registered nurse we spoke with also knew interventions in place for a person who had a high risk weight of 29kg. There was evidence in the person's care documentation of family involvement and the frequency of weight measurement.

At the previous inspection on 8 July and 11 July 2014, the provider was found in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Care and welfare of people who use services. An action plan was received from the provider on 16 December 2014. On this date, the previous set of regulations was in operation. Although the current inspection was under new regulations, we also looked at whether the provider had made improvements since the last inspection and their action plan.

There was good support to the home from health professionals in the community. The local GP surgery provided clinics to people on site twice a week and ensured that minor illnesses were detected and managed, where possible, without transfer elsewhere. Prior to the inspection, we saw from the provider information return that the care home had a higher than average non-elective admission rate for people who use the service. We spoke with two of the GPs who visited the service and their feedback was positive. One GP felt that the higher admission rate for the service was a result of the registered manager's decision to

take some people who had increased care needs over others. Staff were aware of service users' health needs and called in the GP and other health professionals as required. Referrals had been made to people such as dieticians, speech and language therapists, and physiotherapists and their recommendations had been included in the care plans. We also spoke with a local authority's best-interest assessor who was present on site during the inspection. Their feedback was also positive regarding the effective care provided at the home. They suggested that further detailed documentation was required by staff when some care matters were assessed. These included detailed capacity assessments and best interest outcomes specifically related to resuscitation decisions and covert medications

We looked at a total of eight people's care documentation. We found people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The care plans included the person's social history, likes and dislikes, social, cultural and religious preferences, do not resuscitate and end of life plans where appropriate. We saw that people's general health was routinely monitored. One person was noted to be on frequent monitoring programmes for temperature, pulse, respiration and blood pressure. All others had in general routine monthly recording of these observations. Everyone had their weight monitored monthly and more often if required and these were recorded in their individual care plans. One person's preference to have less frequent weight measurement was noted and respected.

We looked at some high risk areas of people's care, like pressure area care, continence care and falls prevention. We saw the pre-admission assessment for each person identified the integrity of their skin. Following this risk assessment, each person with a Waterlow risk score of 15 or higher had a tissue viability or wound care plan that identified the on-going care to prevent or treat a wound or pressure ulcer. The registered manager reported that professional support from a tissue viability nurse (TVN) would be sought for all people with a pressure ulcer grade three and above. This meant appropriate referral to members of the multidisciplinary team when it was required. There were no people with a pressure ulcer identified during the inspection but one person had a venous leg ulcer which was effectively cared for.

The care plan included a wound risk assessment and treatment plan which identified the dressings and bandages to be used. Body maps and recording progress over time were also completed. We saw the TVN had previously visited last on the 17 November 2015. Whilst this person did not have a pressure ulcer they were at risk and we saw them on a pressure relieving mattress which had the correct setting related to the person's weight. This mattress was checked daily and recorded. When we checked ten mattresses and their settings with a care assistant, we found all of them to be set correctly and fully functional.

Outstanding ☆

Is the service caring?

Our findings

Not all people who resided at the care home were able to tell us their personal experience of the care provided. When we asked four people, they told us they all enjoyed living there and had no concerns or complaints. In addition to speaking with people, we observed staff interaction with people who use the service, their relatives and visitors. We saw that staff were kind and compassionate. When staff went to speak with people, they bent down to maintain eye contact if the person was seated. Staff also called people by their personal names during conversations, even if the person was unable to express their understanding or respond. Staff used non-verbal behaviours, like emotion and facial expressions to understand people's decisions or preferences, as best as possible. We observed one person being assisted with their lunch by a care assistant in their bedroom. We saw the person was challenging physically and verbally. The care assistant continued to assist the person eat their lunch, despite the barrier posed by the person's movements. The care assistant spoke persistently patiently with a caring tone. We noted the person's behaviour calmed down sufficiently that they could finish the majority of their meal.

We spoke with four relatives regarding their opinion of care on the day they visited people. All four agreed that the care their relative received was above average. One relative told us: "The care is fantastic. People are not left in a state. Music is the key. I've observed music and dancing sessions and safety is paramount". Another visitor explained: "There are enough staff. They are very caring and have a sense of humour. Staff have a good rapport and know people as individuals". A third relative told us: "Staff are caring and nice to my mother. They kneel in front of her and there are no language barriers. It is warm and safe here". When we spoke to further relatives throughout the inspection, their comments reproduced those we had heard from earlier visitors. Relatives' comments also matched our observation of the direct care provided by staff. One relative told us that the care home was enough of a positive environment that they were able to forge relationships with other relatives and share their experiences.

People's birthdays were celebrated with a personalised birthday cake made by the chef. We saw pictures of the cakes in photograph albums, which included people's surprise upon receipt of the cake. There were also photographs of other special events that people had clearly enjoyed. This included the opening in 2014 of the sensory garden.

The care home regularly and continuously sought feedback from people in order to further improve the service. When we asked the registered manager, they were able to tell us about meetings they had facilitated throughout 2015. For example, we saw evidence of four meetings previously held with people and three meetings with relatives with another one scheduled and pending. We looked at the meeting minutes from the residents' meeting held on 17 November 2015. We saw people who attended were able to have their say on a variety of subjects, including food quality, staffing, cleanliness and activities. People's opinions were recorded and respected. For example, we saw one person requested spaghetti bolognese and lasagne to be included in the next menu. When we asked if this person's feedback was being considered, we were told it would be considered in the kitchen's menu planning. Other people's feedback was positive. Comments in the minutes included: "I enjoy my life here" and: "How nice the food is here at the home".

The provider conducted an annual satisfaction survey with people who use the service and relatives. In 2015, 139 surveys were distributed and 50 were returned. On 3 July 2015 the results showed that 84 per cent of respondents were completely satisfied with the standard of care, 87 per cent thought the management and staff were approachable and that 87 per cent of those surveyed were satisfied with privacy and dignity in the care home. We ask the registered manager which survey response had an area for improvement and saw this was discussion of care provided (with people and relatives) as it scored 79 per cent. The manager had instigated actions following the satisfaction survey result. This included discussions with nurses and care assistants regarding engaging with people about their documented care and a log to record conversations between staff and people about care plans.

The care home had implemented some of the Social Care Institute for Excellence's (SCIE) principles for dignity in care. We observed lunch in one dining room and saw how staff promoted the independence and inclusion of people in simple decision making. Although people earlier had the option to decide from the menu selection, they were again asked before the food was plated in case they wished to change their mind. For people where verbal communication was problematic, a staff member took the freshly plated main meals to each person and showed them what was on offer. The person was then able to point to one or show their facial expression to help staff interpret which dish to serve. When we asked two of the care assistants present in the dining room, they were also able to tell us people's individual food preferences without reference to care documentation. They told us this helped them to determine what people might prefer or not like to eat or drink. We observed that lunch was calmly organised and undertaken by staff, which enabled people to have an enjoyable meal experience. People's call bells were quickly answered and no one had to wait for staff to attend to their needs.

Throughout the inspection, we observed people who were independent or mobilised with some assistance were appropriately dressed, their hair was neatly done and some people wore make up. In each encounter we had with people in hallways or communal spaces, we saw they wore shoes and were transferred out of wheelchairs to sit on the furniture instead. During personal care, we saw staff closed people's bedroom and bathroom doors, and other staff that needed to enter always knocked and sought consent to open the doors. There were 'do not disturb' signs which staff hung on the door handles to show that personal care was taking place. In addition, the location had adopted the NHS England Chief Nursing Officer's 'culture of compassionate care' in their philosophy of care provision. This embraced care which was compassionate, competent, committed, and courageous and communicated. Staff had visual reminders as they worked throughout the building with dignity and privacy cartoon posters as subtle reminders of their interactions with people who used the service.

Outstanding ☆

Is the service responsive?

Our findings

After receipt of a large grant in 2014 from the local authority to improve people's experiences of living with dementia, the care home set the activities coordinators a project to use this to people's benefit. This included refitting and refurbishing entire floors of the building and creating a sensory garden. On each floor, memorabilia was installed to help people reflect on history and their life growing up. Examples included signage from historical television commercials and shows, famous historians and musicians. When we toured the floors, we saw that people's bedroom doors were painted different bright colours. When we asked about this, we were told that this helped people suffering with confusion or memory loss to orientate themselves and acted as a point of reference. Each person also had a memento box installed outside their bedroom. These contained keepsakes and trinkets the person had either brought with them or their family had delivered. The memento boxes provided a discussion point with people who lived at the service but also a method of orientating the people to their own life. We saw staff completed this as we inspected.

When we spoke to the registered manager, they explained they had used the NICE guidelines to aid the location's decision making about using the funding. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. We looked at other examples of how the service provided responsive care. We saw that alcoves along long corridors had been fitted out with small sets of chairs. These encouraged people who had a tendency to wander instead to sit down and enjoy a short break. We observed people who did this as part of the inspection. During the inspection and despite the number of people with dementia diagnoses, no one exhibited behaviours that challenged the service. They could also experience coloured and textured puzzles or art mounted to the walls of corridors. In lounge areas we heard music playing from the 1930s-1960s and saw it was played on record players and jukeboxes. People we observed sitting by the music were engaged, singing and enjoying the experience. On tables, there were puzzles which staff actively engaged people in and we saw they were interested and participated.

Research from Stirling University on how to provide the best care for people with dementia was consulted and implemented by the provider. In one room we visited, the entire room was set up as if it was in the 1940s. We saw there was books, newspapers and furniture from the period. People and their relatives could enter when they liked and have a relaxing conversation or refreshments there. In communal bathrooms, enormous murals had been painted onto the walls to brighten the room and provide discussion points between people who use the service and staff. For example, one bathroom had a Wales seaside community painted on it. Another room was set up as a sensory room. A sensory room is a space for enjoying different sensory experiences and where gentle stimulation of the senses could be provided by a staff member in a controlled way. We saw there was a disco ball, bubble columns, image projector, coloured optic fibres and fabric to stroke and plait. On one of the days of the inspection, it was also the one year anniversary of the sensory garden opening. We saw people went out with staff to enjoy the mild weather and interact with the scents, textures and colours of specially selected plants, observed mobiles and listen to wind chimes. A person we asked coming back into the building told us they enjoyed the garden experience.

The service encouraged people's interests and choices. The care home had an extensive range of on-going

activities for people to take part in. When we spoke with care staff, they knew what activities were held on the days of the inspection as well as on other days. They were able to tell people that used the service what was on for the day and what was coming up. On the ground floor, we observed a prominently positioned notice board specific to activities, which contained the upcoming calendar of events. Surrounding this, were photographs of prior special events, community links and social engagements. On one of the days of the inspection, a clothing party had been held where people could choose to view new clothes and place an order for them if they wanted. A hairdressing salon was available on site and we saw people had their hair cut and styled. We also met a relative who was a local vicar and spoke with them about their role. They told us they had a high opinion of people's involvement in social activities, and that they provided religious services to the care home when requested. Another relative we spoke with was satisfied by the activities offered, but told us they wished that more activities were offered on the second floor. Two people we spoke with enjoyed sitting with staff members to participate in puzzles and told us that staff always engaged them in conversation.

We looked at 14 people's care documentation. The provider used a specific nursing model of planning, implementing and evaluating care that ensured people had a holistic experience at Sandown Park Care Home. For example, routine activities of daily living like eating or drinking, breathing and elimination were covered. However, less likely topics of care planning like work and leisure, self-expression and intimate relationships and end of life care were included for each person. We examined the content of care planning and documentation to check whether it was specific to people's needs. We saw that people's individual preferences were included, that choices were offered to people when possible and that care was reviewed monthly or more frequently if the person's condition required. People had life stories recorded that explained the person's history prior to life at the care home. Documented interventions were comprehensive and detailed. For example, one person with an indwelling urinary catheter had extensive information recorded about the type and care of catheter, prevention of infection, dignity and privacy and collection of any needed specimens. In another person's file, we saw the contemporaneous records kept for someone with a wound. This included information like the type of mattress and skin integrity, creams and lotions, the person's compliance with nursing care, wound assessment and treatment plans and body mapping. The care files we examined demonstrated the provider's focus on ensuring people's care was responsive to their needs.

We looked at how the provider encouraged, received, investigated and responded to complaints. We saw signs throughout the building and in people's 'service user guides' that provided information about how to make complaints both internally and externally. We saw the provider had a complaints policy dated August 2013 but also a policy for duty of candour dated July 2015. The duty of candour means the provider must be open and transparent with people and other relevant parties. The policies outlined the duties of the location and registered manager for complaints or matters where an injury occurred that required a written apology. We saw the registered manager maintained a complaints log for all complaints and concerns and detailed information was recorded. We saw for one complaint in May 2015, an extensive investigation was conducted which included interviews of necessary people and witness statements from staff. Written acknowledgement and outcome letters were sent to anyone who raised concerns. The registered manager's focus was to ensure that people's and relatives' experience of care was to their satisfaction, and if it was not, what could be done to improve. When we spoke with four staff about complaints, all of them knew what to do if a person or relative made a complaint and they were also able to tell us how they would deal with complaints about the management team.

Good

Is the service well-led?

Our findings

People and relatives were openly encouraged to contribute to the development of the service. We saw numerous occasions during the inspection where staff, a visitor and a person who used the service were engaged in a conversation and the staff member took the outcome of the discussion to the deputy manager or registered manager. We saw the registered manager often greeted people on the units and visitors as they entered the front door and had discussions about care with them. The care home maintained strong ties with the local authority, commissioners and members of the multi-disciplinary team also. We looked at two sets of meeting minutes with one commissioner from meetings held in January and April 2015. We saw that the provider was transparent in their communications with the commissioner. For example, there was recorded open discussion regarding complaints, incidents and injuries, staffing levels and staff training. The care home reviewed previously outstanding actions from prior meetings and set new actions for completion prior to the next review meeting.

The provider had a registered manager in post. There was continuity in the leadership at the care home with a single registered manager since registration of the location and some changes in the provider's registration in 2014. The registered manager and deputy manager provided strong leadership for the care home. In all aspects of the management, they had oversight and were able to provide detailed information about the staff team, people who used the service, areas of strength and items for improvement. People, staff and relatives we spoke with commented on the quality of the management. One person told us: "There are no complaints; if I was concerned I would raise it because they [the managers] are amenable". A relative we spoke with commented on the registered manager. They said: "She's very good. Efficient, quick, smart and very thorough. No areas for improvement". A staff member told us their opinion of management: "[The manager] runs the home very well. She's firm but fair. I'm very happy". Another staff member stated: "My manager is supportive and approachable. She comes to the home if we are short staffed".

In preparation for the inspection, we checked the content of the provider information return (PIR) submitted by the provider on 20 July 2015. This contained objective data about reported certain events at the care home, for example death notifications, serious injuries and DoLS outcomes. We compared this with the content of the CQC database and with records on site. We noted that no omissions had been made by the registered manager in submission of notifications. We also saw that when near- miss events occurred which required reporting under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013), the management were prompt to send these. When we spoke with the registered manager and the deputy manager, they were clear of their obligations to notify statutory incidents and events, and the investigations and documentation that related to them. The registered manager showed us that tracking lists were used to ensure that no notifications were missed. We asked about the low rate of safeguarding events notified to the CQC. The registered manager provided evidence that all safeguarding matters were reported to the local authority, but social workers the care home worked with decided that the matters often did not reach the threshold for treating as abuse or neglect.

The care home's approach to quality was demonstrated in a number of ways. These included participation in valuable research that could further improve the lives of people in residential or nursing facilities and

people with dementia illnesses. We looked at two projects the care home was involved in. In association with Guy's and St Thomas' NHS Foundation Trust, people at the care home had consented and participated in clinical trials of a new medication aimed at reducing hallucinations in people with Alzheimer's disease. Hallucinations are sometimes a related result of using antipsychotic medication in older adults. We looked at the records related to one person's participation, and saw they were in line with the requirements of clinical research. These included signed valid consent, information for the person subject to the trial and other associated documents completed by nursing staff. In total, five people from the care home were using the trial medication (or placebo).

In the second trial with funding from Health Education England, a project officer worked with the care home to commence the use of handheld computer tablets by staff to electronically record people's health and welfare. The purpose of the research was to aim for harm free care and the prevention of non-elective admissions to hospital. Using Wi-Fi internet, staff carried the computer tablet around and interacted with people or observed their condition. Using a number of criteria and simple scoring, care assistants recorded a rating for areas like hydration, skin integrity, weight and mouth care. Consent was required from people who use the service and this had been obtained for people that participated. Measurement of people's welfare was recorded daily or weekly depending on the risk to the person's ongoing health. Data from the tablets then populated a report dashboard to the management. The information for management alerted management where there was a health decline over time or where a person's condition had suddenly deteriorated. Four care homes were involved in the research and Sandown Park Care Home was in the second week of the trial at the time of the inspection. Care staff we spoke with told us they enjoyed using the technology and it helped them to focus more on people's care needs and monitoring of them.

The care home also completed a number of internal audits to check on the standard of care and where improvements could be made and we viewed a variety of these during the inspection. The registered manager told us they had completed a formal internal auditing course to prepare them with the knowledge and skills to look at areas for better standards. Surveys included monthly medication audits, monthly whole of service audits, infection control audits, and a 'quality monitor' comparison against the provider's other locations. Another audit that the care home undertook included a dignity audit twice a year, with the last result being 'green' in July 2015. The dignity audit examined people's environment, communication with staff, privacy and staff training. Other audits in November 2015 included ones on food and activities.

When audit results revealed areas for improvement, the managers compiled an action plan and, if necessary, a risk assessment. We saw the action plan from the whole of service audit on 2 November 2015. Actions included re-writing a person's care plan for mobility and cleaning a mechanical hoist which had some marks. The auditor concluded the report with: "The manager and deputy have a very high standard of keeping the home to a good standard from all aspects of care to residents and staff". External audits were also undertaken on different aspects of the care home quality. An example was the local authority environmental health officer (EHO) food hygiene rating conducted in March 2015. The care home received five out of five 'stars'. We also saw that the provider was registered with the Information Commissioner's Office (ICO) for the handling and storage of confidential personal information and that both the registered manager and deputy manager had successfully completed Preparing to Teach in the Lifelong Learning Sector (PTLLS). This allowed the registered manager and deputy manager to participate in training staff about any topic where enhancement was required for people's better care.