Care Quality Commission

Porthaven Care Homes Limited

Wiltshire Heights Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 07 and 10 August 2015 and was unannounced. At the time of the inspection the service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.Wiltshire Heights care home provides accommodation and nursing care for up to 63 adults, some of whom are living with dementia.

People were not protected against the risk of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. There was a lack of information and guidance for staff on how to support people safely and consistently. Medicines were not organised and administered in a safe and competent manner. There were errors in the recording of medicines and a Registered Nurse on duty told us that one person had run out of their medicine. Staff who administered the medicines did not adhere to safe practices. The manager could not find the stock ordering sheet for the medicines as the staff member who carried out the ordering was on holiday.

Summary of findings

People sometimes did not have access to the equipment they needed. Not all staff were knowledgeable about the equipment in place and staff did not monitor if the equipment was being used appropriately.

Staff had not received training relevant to the people they cared for. Not all of the nursing staff had competence in the core skills of: taking blood, using a syringe driver and catheterisation. The nursing staff relied upon the availability of the district nursing team to carry out certain procedures or to supervise the nursing staff to perform them. Some people who lived at Wiltshire Heights care home had different types of behaviours which may challenge others. None of the staff had received training in how to manage these behaviours and to keep themselves, the person and other people safe.

We reviewed the care records of twelve people on the dementia and the nursing floor. We found that mental capacity assessments had not been completed for some people who were unable to consent to moving into the home or their care and treatment. Where capacity assessments had been completed they were not specific to the reason for the assessment.

The standard of record keeping was poor with missing information and records which had not been completed fully. The care records did not accurately reflect the care being provided or required.

The nursing floor did not have a clinical lead and there was a lack of leadership and support to the Registered Nurses.

People told us they enjoyed the food however, some of the food was cold. Not everyone received appropriate support to eat and drink and some people did not have specialist crockery to support them to eat independently. People had access to food and drink throughout the day and the chef went out of their way to ensure that people had the treats they liked.

The systems in place used to assess, monitor and improve the quality, safety and welfare of people were not fully effective. Some audits did not identify where standards were not met.

Staff received supervision and training and the new care certificate had been introduced. The home was in the process of setting up dates for appraisals.

The home was purpose built on three levels and the building was fully wheelchair accessible. Communal areas were bright and hallways were wide and straight which meant that people could walk unsupervised.

Staff were caring, kind and respectful towards people and we saw that people and staff had developed positive relationships. However not all staff waited to be invited into the person's room when they knocked.

There were safeguarding and whistleblowing policies and procedures in place which provided guidance on the agencies to report concerns to. Staff had received training in safeguarding and whistleblowing to protect people from abuse and training records confirmed this.

The provider had audits in place in relation to the safety of the buildings and fire safety.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that this service has been placed into 'Special measures' by CQC. The purpose of special measures is to: Ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there

Summary of findings

is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks assessments did not give sufficient guidance to staff on how to support people to be safe.

People could not be confident that their medicines were organised and administered in a safe and competent manner.

The level of cleanliness throughout the home was of a very high standard.

Inadequate

Is the service effective?
The service was not effective.

Not all of the nursing staff had competence in the core skills required.

Staff had not received training to be able to safely support people with behaviours which may challenge.

People told us they enjoyed the variety and quality of food on offer.

Inadequate

Is the service caring?
The service was not always caring.

People's care records and other information was not always securely locked away.

People liked the staff and we saw people were treated with kindness and respect.

Information was available to people about the use of advocacy services.

Requires improvement

Is the service responsive?
The service was not responsive.

The care records did not accurately reflect the care being provided or required.

There was a lack of information relating to how the person spent their day and their social interaction and positive outcomes.

People took part in a range of activities.

Inadequate

Is the service well-led?
The service was not well led.

The service had not had a registered manager in place for nearly a year.

There was a lack of clinical leadership and lines of accountability on the nursing floor.

Staff said the manager was approachable and they had an open door policy.

Inadequate

Wiltshire Heights 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. We also followed up non-compliance which had been identified during a previous inspection on 13 August, 18 and 17 July 2014.

The inspection took place over two days, 07 and 10 August 2015 and was unannounced. The inspection was carried out by one inspector, a specialist advisor who was a specialist nurse 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.

We spoke with 15 of the 37 people living at Wiltshire Heights care home. We spoke with eight visiting relatives and friends about their views on the quality of the care and support being provided.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to assist us to understand the experiences of the people who could not talk with us. We spent time observing people in the dining and communal areas.

During our inspection we spoke formally and informally with the regional manager, the manager, the residential care manager on the ground floor, a med tech [this is a member of care staff trained to administer medicines], the home administrator, three nurses, five care workers, the chef, two members of the housekeeping team and the activities co-ordinator. Before our visit we were contacted by five health and social care professionals.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of thirteen people. We looked at staff records relating to recruitment and supervision. In addition, medicine administration records, information on notice boards, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the two days of the inspection.

Inadequate

Is the service safe?

Our findings

Following an inspection of Wiltshire Heights Care Home on 13 August, 18 and 17 July 2014 we found the provider was in breach of regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulation 2010, Records. We did not see how some people's behaviour was managed if they became agitated and anxious. For one person their risk assessment did not always include information on how to keep them safe when their behaviours changed. Although there was a mental health plan this did not show staff how their behaviour should be managed.

During this inspection we found that the home had not addressed the issues identified at the previous inspection in protecting people against the risks of unsafe or inappropriate care and treatment arising from accurate and appropriate records not being maintained.

We looked at the risk assessments in place on the dementia floor, particularly for those people who may exhibit behaviours which challenge others. They did not fully identify what the risks were or give sufficient guidance to staff on how to support people to be safe and ensure that all staff were consistent in their approach. There was a lack of information about the triggers which may lead up to an incident and how staff could recognise these in order to minimise the risk of escalation. Positive behaviour management strategies had not been put in place where the behaviours of one person impacted on others.

Risk assessments gave instructions on how to support people but these were not descriptive. How staff were to support the person was dependent on how they interpreted the information. For example the risk assessments used words , such as 'prevent injury', 'occasionally', 'encourage the person', 'can be verbally aggressive or abusive'. This was further compounded by the fact that staff had not received any training in managing behaviours which challenge. Should the occasion arise, staff had not received training in how to safely and lawfully use restraint. This posed an additional risk that staff would not be able to support people in a consistent and safe way.

Within the daily records we found that information relating to actual or potential incidents were not fully recorded and not followed up with an incident form. Such as 'X was aggressive towards Y' without any explaination of what this entailed. One line stated 'X aggressive' with no further information as to how the aggression presented itself or if there were any triggers for the behaviour. We found that incidents were being recorded as accidents and there was a lack of understanding between the two. Due to this there was a lack of robust information which could be analysed in order to mitigate risks to individuals.

Care plans did not contain sufficient information to enable staff to support people safely and appropriately. This was in relation to food and fluid charts, wound assessments, challenging behaviour, mobility, personal hygiene and skin integrity. Charts were either missing, had not been completed or were not fully maintained.

There was a lack of information relating to the risk of social isolation for people who preferred to stay in their room or were not able to leave their room. For people who did not wish to leave their room, there were no risk assessments in place regarding social isolation and how this would be managed. For one person who did not wish to leave their room, the monthly activity record stated 'doesn't want to leave room, happy with self for company and listening to the radio'. However, information from within their care records documented that this person enjoyed crafts. There was no evidence that this person had been offered activities which they enjoyed.

Before people moved into the home, a pre-admission assessment was carried out to ensure the home could offer the appropriate support the person required. We looked at a pre-admission assessment for one person, however, it had not been fully completed prior to the person moving into the home. For another person, the pre admission assessment identified the person declined help and support from staff. There was a lack of information at the pre-admission stage to fully determine the home had the appropriate resources such as the staff skills, or develop strategies for staff to follow in order to support and care for this person appropriately

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service could not be confident that their medicines were organised and administered in a safe, competent manner. Their medicines were not always available and errors in recording were made. We could not be assured that people received their medicines as prescribed.

Inadequate

Is the service safe?

People were not safe because of poor staff practice. We observed the member of staff administering the medicines to people living with dementia. The carer wore a red tunic so as not to be disturbed. The regional manager, a visiting foot care professional and a person all interrupted the staff member whilst they administered the medicines. The foot care professional spoke to the person administering the medicines and the carer left the medicine trolley in the charge of the regional manager to speak with a person in their room. They did not tell the foot care professional that they should not be disturbed. Following this, the staff member left the medicine trolley with the key in and went to get a drink of water for someone. They then went into the medicine office and got a bag out for another person. They also answered the phone. This practise could increase the risk of medication errors.

On the nursing floor we observed the Registered Nurse administering medicines. They tried to ensure they were not disturbed during the medication round and wore a red tunic to warn people they were giving out medicines. We saw other staff and people, including the regional manager talk to them on several occasions. Interrupting a care worker whilst they administer medicine may cause errors due to a break in their concentration.

On the dementia floor, we sat in on the handover between the night and day shift care staff. The night shift registered nurse told us and the day shift nurse that one person had "run out of their medicine". We asked the day shift nurse to follow this up and they told us it was 'not their job as they did not order the medicines'. This demonstrated a lack of accountability for the people in their care.

We asked the manager if the medicine for this person had been ordered, they were not able to tell us. This was because they could not find the stock ordering sheets as the staff member responsible for the ordering was on holiday. The manager later spoke with the member of staff on the telephone who said they had placed the order.

We reviewed the medicine records of eight people on the nursing floor. There were errors in the recording for six people. Within the medicine administration records, signatures were missing, there were gaps in recording in relation to drugs for diabetes, parkinson's, alzheimer's and fluid build-up. Protocols were not in place where people required PRN medicine [PRN is medicine which is given as and when required]. There was a lack of information on the recording of topical creams regarding how, when and where to apply them. Staff were not following the instructions of the GP when the person did not take their medicine.

Due to the issue with the member of staff responsible for ordering being on leave and other staff not having knowledge of the medication ordering system, we were not able to review the medicine stock ordering sheets against the levels of stock held. We could not therefore be assured that people did always receive the medicines which they had been prescribed.

This was a breach of Regulation 12 (1) (2) (g) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a variety of equipment used by people to support their independence, maintain good health and ensure that staff could support them safely. However, people sometimes did not have access to the equipment they needed, not all staff were knowledgeable about the equipment in place and staff did not monitor if the equipment was being used appropriately.

One person who had experienced a fall the day before, was resting in bed. We saw that the call bell had been clipped to the bedside light lampshade. This was not within reach of the person who would have had to reach over the side of the bed to reach the call bell. This posed a risk of pulling the light over and the person potentially falling out of bed. Staff had failed to recognise the increased dependency of this person following a fall.

Another person had a sensor alert mat on the floor; the way it was installed meant that it was linked to the call bell system. The person told us that an agency worker kept accusing them of pressing the call bell. They stated they hadn't. The agency worker did not recognise that as the person's feet were on the mat it was activating the call bell. The person told us they were very upset by the accusations from the agency worker.

We noted that one person had a sensor alert mat positioned beside their bed, between the bed and the en-suite bathroom. The person was sitting the other side, between the bed and the window. This person's falls risk assessment identified them as being at high risk of falls with a low rise bed and the 'step' mat to be near to the person's feet at all times and at the bed side at night. Staff

Inadequate

Is the service safe?

had not ensured that this person's equipment was in the right position in order to make them aware of when the person mobilised and help to reduce the risk of them falling.

This was a breach of Regulation 12 (1) (2) (f) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safeguarding and whistleblowing policies and procedures in place which provided guidance to staff about the agencies they should report concerns to. Staff had received training in safeguarding and whistleblowing to protect people from abuse and training records confirmed this.

During the inspection, we found that call bells were answered promptly. Staff went about their tasks in a unhurried manner. On the 10 August 2015 we visited the home at 7.30am and found the home calm and people were either getting up gradually, having a cup of tea in bed or still asleep.

Staff told us that they thought there was enough staff to support people appropriately and safely. People told us that on the whole there was enough staff, although at times they may have to wait until a member of staff was available. A relative told us that since the new manager had started at the home, the staffing seemed to have improved. A relative told us they thought they could do with more staff at the weekends.

The staff roster's demonstrated that the staffing levels which were calculated by dependency levels, were being met. The manager told us that at this time they did rely upon agency staff to ensure their staffing levels. We saw documents which evidenced that the home recalculated the staffing hours required each week, based upon people's changing dependency needs and those of new people coming into the home. However, we did question one person who was assessed as requiring a low level of support which we did not agree with. We spoke with the manager about this.

The premises smelt fresh and was free from odours, there were no infection control issues identified during the inspection. The level of cleanliness throughout the home was of a very high standard. There appeared to be enough cleaning materials and equipment available to domestic staff to enable them to do their job. A member of the housekeeping team told us 'I like to clean room carpets when residents are at lunch so that I don't disturb them' they also told us they really liked their job and enjoyed working at the home because they could 'talk to the residents'.

The provider had risk assessments in place for the environment and facilities, such as ensuring that the water systems were regularly checked for legionella. [Legionella is a disease which is caused by bacteria in water systems]. Fire equipment was regularly tested. The home was well maintained and safe throughout. The layout of the building promoted people's independence, dignity and safety. The communal areas of the home were clutter free, spacious and accessible for wheelchair use.

Inadequate

Is the service effective?

Our findings

Following an inspection of Wiltshire Heights Care Home on 13 August, 18 and 17 July 2014 we found the provider was in breach of regulation 9 HSCA 2008 (regulated activities) Regulation 2010, Care and Welfare of people who use services. The home admitted some people without ensuring that suitable arrangements were in place to meet individual needs, prior to admission. The home sent an action plan to tell us how they were going to address our concerns.

At this inspection we found the home had not addressed the issues identified on 13 August, 18 and 17 July 2014 in relation to the skills and knowledge of their nursing staff, in relation to the care and support that people in the nursing unit required. We found not all of the nursing staff had competence in the core skills of: taking blood, using a syringe driver, peg feeding and catheterisation. The nursing staff relied upon the availability of the district nursing team to carry out certain procedures or to supervise the nursing staff to perform them.

Before our inspection on 7 and 10 August 2015, the district nursing team raised concerns with us regarding the skills and knowledge of the nursing staff at Wiltshire Heights and the amount of support they had to provide to the staff at the home to meet people's needs. They had raised the same concerns in 2014. An example of the concerns raised were, nursing staff not being able to calculate the correct amount of water to diamorphine for a syringe driver and not removing a tourniquet before the syringe, when taking blood.

Staff had not received training relevant to the people they cared for. Some people who lived at Wiltshire Heights had behaviours which may challenge others. None of the staff had received training in how to manage these behaviours and to keep themselves, the person and other people safe. The manager told us they would be arranging for specific training around these needs. In addition, we found the activity co-ordinators had not received specific training. This related to engaging people in meaningful occupation and developing activities for people with a dementia.

Care records evidenced health and social care professionals, such as the district nursing team, speech and language therapy and podiatry services were involved in people's care. However, people were not always referred to professionals when required. Examples were, one person had lost a considerable amount of weight and should have been referred to a dietician, this only occurred when the GP visited and asked this to be done. There were also delays in involving the mental health team when people's behaviours changed.

This was a breach of Regulation 12 (1) (2) (c), Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards is part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make a certain decision and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Staff told us and the training matrix evidenced, that staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we found that this training had not been fully effective as there were varying levels of understanding from staff around how the MCA and DoLS should be applied in their roles. The manager confirmed that further training would take place to ensure staff were confident in their knowledge.

We reviewed the care records of twelve people on the dementia and the nursing floor. We found that mental capacity assessments had not been completed for those who were unable to consent to moving into the home or their care and treatment. Where capacity assessments had been completed they were not specific to the reason for the assessment. We saw capacity assessments where the reason for lack of capacity was given as 'lacks insight' and 'person has alzheimer's, decision due to alzheimer's they lack some capacity, able to make some decisions'. The reason for assessment was not clear, what the decision being made was or what decisions the person could make. There was a lack of recorded evidence of how people had

been involved in the decision and a lack of evidence that best interest meetings took place prior to the final decision being made. Some mental capacity assessments had not been signed to evidence consent.

One person had a photograph of themselves in their care plan yet the consent to photographs had not been completed or signed. One person had not had a mental capacity assessment several weeks after moving into the home. We spoke with the manager about this. There was conflicting information between the mental capacity assessments carried out by the home and the information in the professional records. The mental capacity assessments in place did not consider a date for review and there was no evidence that capacity had been discussed during the person's quarterly care review to ensure they were still valid.

The home had made DoLS applications to the managing authority and were awaiting the outcome of these. However, we looked at one DoLS application which stated the reason for the application was the person was to be prevented from moving between the three floors. There was a lack of understanding that the home were preventing the freedom of movement of the person, whether inside the home or outside of the home.

We looked at one Do Not Resuscitate form (DNAR) and found the GP had signed the form, yet the back section which considered the capacity of the person to make that decision had not been completed. It is the responsibility of the home to ensure the process of determining capacity for decision making is followed as legally required. We looked at another DNAR form which had been completed by the GP. There was no record of a discussion with the family as the form assessed that the person had capacity to consent to the decision in the DNAR form. However, the mental capacity assessment had conflicting information with the 'can remember' box being ticked in one line, then in the text later it stated the person couldn't remember and was not able to make this decision.

This was a breach of Regulation 11 (1) (2) (3) Need for Consent of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

During the two days of the inspection we observed the lunch time over the three floors. We also looked at the support people received whilst eating in their room. We found people did not always receive appropriate support to eat their meal. One person was given their lunchtime meal in their bedroom at approximately 1pm. At intervals, three staff went in and asked why they had not eaten their meal. None of the staff encouraged the person to eat, offered support or asked if the meal was still hot. The meal was still there at 1.45pm and the hot bread and butter pudding was now cold. We asked this person if we could get anyone to help them but they told us "I'm eating it now". A member of the inspection team joined people for lunch. However, we found that some items of food were cold, such as the chips. The chef told us they had raised this with the lack of equipment to keep the food hot with the provider.

We observed the meal time on the nursing floor where three people choose to eat in the dining room. Care staff were serving food and taking trays to the rooms. There was a lack of specialist crockery to support people to be able to eat independently. One person kept losing the peas over the side of their plate and was chasing them around with the fork. A plate with a rim would have resolved this issue. Two members of staff began to help the person at different times but left the person quite quickly to take the trays to people's rooms. This meant the person had to wait until staff were available to finish eating their meal.

During lunch time on the dementia floor, we saw one person was not hungry and refused their lunch. They couldn't decide what they wanted to eat and appeared confused as to what the items looked like. Staff did not show this person the plates of food on offer to enable them to visualise their choice. This resulted in the care worker cutting a portion of fish in half and giving this to the person. However, another person was shown the plates of food to enable them to make a decision about what they wanted to eat. There were no picture menus in place to assist people to choose their meal. In addition, meals were chosen the night before which could impact on the independence of a person with dementia, who may not be able to remember what they had ordered the day before.

One person was eating a salad, they had finished the lettuce but the tomato and cucumber remained on the plate. The person was trying to use their knife and fork to cut the items but was not able to. A member of staff was sat with them at the time but did not offer to cut up the food. Ten minutes later another member of staff took over and immediately asked if the person would like their food cut up, they responded "Yes" and finished their meal. One

person had their meal interrupted to be taken to their appointment with the visiting foot care professional. The member of staff did not suggest they wait until the person had eaten their dessert.

On each of the three floors we found there were times when staff did not explain what the food was to people. On one occasion the member of staff put down the plated meal in front of the person without saying anything to them, before walking away to serve another person.

This was a breach of Regulation 14 (1) (2) (c) (d) Meeting nutritional and hydration needs, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chef told us that this was the best food they had ever sourced regarding the quality and freshness of the produce. 'The encouragement to eat is that the kitchen will provide anything from the menu which includes three starters, choices of main course and dessert, and other choices should this not be what people want to eat.' The chef said that they catered for different dietary needs and were involved with various health professionals where people had specific needs such as, pureed diets.

Snacks and drinks were available to people throughout to people the day. On Friday 7 August 2015, the ground floor dining room served a main course of either fried fish or turkey and ham pie with chips and/or mash and vegetables of peas or sweet corn. Staff asked people what they would like to eat and most people had looked at the menu on the table and decided what they wanted. No-one required support to eat and drink. One person had a pureed diet, and a few people preferred to use a spoon instead of a knife and fork.

On the ground floor, staff encouraged people to be independent when eating and drinking and were available to discretely assist if needed. Everyone had a drink and refills were offered. The member of staff was very attentive and knew of individuals preferences asking them without referring to the list supplied by the kitchen. People were offered tea or coffee after lunch and when one person was asked if they wanted sugar they called out "I can put it in myself thank you." One person told us they did not like the biscuit they had with their afternoon tea saying "you think of the money we are paying they could at least afford nicer biscuits".

Staff told us they received supervision and the manager was in the process of putting together a timetable for annual appraisals. The standard of recording on some of the supervision documents was inconsistent, with some supervision records not giving a description of the conversation which took place and the actions to follow towards the member of staff's development plan. We discussed this with the manager.

A training matrix was in place and staff confirmed they received mandatory training required by the company, such as safeguarding, infection control, manual handling and health and safety. Some staff had also received training specific to their role such as dementia awareness and medicine management. The provider had introduced the new care certificate and new members of staff were to undertake this qualification.

The home was purpose built on three levels and the building was fully wheelchair accessible. Communal areas were bright and hallways were wide and straight which meant that people could walk unsupervised without the risk of knocking themselves on protruding walls. There were hand rails on both sides of the walls throughout all of the communal areas. In addition, bathroom and toilets had grab rails for support.

There were colour changes on the walls between the different floors of the home. On the dementia floor we found there was a lack of co-ordinating colour, for example to highlight doors such as the toilet. And, by the use of larger picture signs which would support people with dementia, who required visual orientation to maintain their independence.

Requires improvement

Is the service caring?

Our findings

Following an inspection of Wiltshire Heights Care Home on 13 August, 18 and 17 July 2014 we found the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, Records. Some people's care files were left out on the nurses' station unattended on the first floor and not kept secure. There were often visitors walking past these areas and we were concerned that people's information was not always kept confidential. The provider sent an action plan which stated how they would address our concerns relating to security and confidentiality of people's information.

During this inspection we found that the provider had not addressed the concerns raised at the previous inspection. People's personal information was not kept secure so that it remained confidential. Across each of the three floors, cupboards containing people's care files were not locked and on the dementia floor, the key to the cupboard was left in. In addition, personal information such as monitoring charts were left on top of the filing cupboards on each of the three floors. On the nursing and dementia units, staff left care plan folders on top of the staff station desk. Within one person's care plan, we saw a photograph in the file of the person's pressure sore around the sacrum. The photograph was not contained in an envelope to protect the person's confidentiality and dignity.

This was a breach of Regulation 17 (1) (2) (c) Good Governance, Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

During our inspection the three members of the inspection team saw many occurrences on each of the three floors, of staff knocking on doors prior to entering but not waiting for a response to be invited in. This practice demonstrated a lack of consideration for the person's privacy and right to choose if they wished the person to come into their room at that time. One person told us "they look after me well most of the time, but at night they can be a bit abrupt walking in without waiting after knocking, and they don't always knock".

This was a breach of Regulation 10 (1) (2) (a), Dignity and Respect, Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they liked the staff and commented "staff are lovely and try really hard' and "they [the staff] are really kind". We spoke with two relatives who said "mum has mild dementia and gets a bit mixed up at times but mostly has capacity to recognise and make decisions fine. We are very happy with the day staff who treat mum with dignity and respect". Another relative told us they were very happy with things and felt they would be able to raise a concern or make a complaint if they needed to.

We saw many examples of positive interactions between people and staff. Staff promoted interaction through eye contact, smiles, getting down to the person's level to speak with them. One person told us "the staff have good relationships with people".

The health of one person had deteriorated over the weekend. We observed that staff supported the person and their family in a caring and dignified manner. Staff asked the visiting GP to speak with the family to ensure they were given information and an explanation about their relative's condition and care needs.

People appeared comfortable and relaxed in the presence of staff. Staff spoke with people in a warm and caring manner. Staff were respectful towards people and asked permission from the person before offering support and care, such as asking "is it okay to take your tray now" and offering choices such as "do you want to go outside or into the lounge". Staff encouraged people to be independent saying to one person "walk a little way and I'll get the wheelchair for the rest" and "you try yourself and I'll help if you need me".

Information was available to people and their families regarding advocacy services. One person was currently using the services of an advocate. This would support them to voice their opinion and make their own decisions. [Advocacy is a process of supporting and enabling people to express their views and concerns and access information and services through an impartial service which is independent of family or the service]

The chef in the home went out of their way to ensure that people had the foods and treats they liked. On their day off, the chef would shop for specific items people had requested. The chef told us that one lady loved Dover sole but he was having a lot of trouble finding it – when the fish stall at the farmers market was mentioned he said "that's good it's my day off tomorrow, I can go there and get some". Staff were attentive to people's requests and preferences. During lunchtime, one person said to the

Requires improvement

Is the service caring?

member of staff, "I only want beans if they have a snap". The member of staff went and got a single bean on a plate and cut it before informing the resident that "yes it did have a snap".

Resident and relatives meetings were held and the chef said he attended these meetings to gain people's views on the food and choices available. "I also follow up anything put in the comments book".

Inadequate

Is the service responsive?

Our findings

Following an inspection of Wiltshire Heights Care Home on 13 August, 18 and 17 July 2014 we found the provider was in breach of regulation 20 of the Health and Social Care Act 2008 (regulated activities) Regulation 2010, Records. The provider had not ensured that people were protected against the risk of unsafe or inappropriate care and treatment arising from the maintenance of proper information about them. This was because an accurate record for each person in relation to their care and treatment was not maintained. The provider sent an action plan to us to tell us what improvements they would make.

At this inspection we found that the home had not addressed the issues identified on 13 August, 18 and 17 July 2014 in relation to records. The care records did not accurately reflect the care being provided or required. The quality of recording was inconsistent. Some sections lacked sufficient detail, had incorrect information or did not give adequate explanation. This may impact on the safe delivery of care and the health and well-being of people.

Staff completed a daily record of the care people received and details about how people had spent their day. None of the records we looked at made a clear and descriptive reference to the emotional well-being of the person. There were no indicators of how people expressed their emotions to enable staff, particularly agency or new staff to be aware of what it meant when people were described in the daily notes as 'depressed' and 'appears to be in good spirits'. There was no description of what these behaviours meant for the person. Emotional well-being is an important indicator of when someone may be in pain. A lack of recording which describes behaviours or actions taken may prevent staff sharing important information and assist in ensuring that timely and appropriate support was planned and given. This is particularly important given the high number of agency staff used.

Each person had a care plan in place which detailed the support the person required in relation to their health, mobility and personal care needs. Care records documented people's preferences in relation to their care and daily living. The guidance for staff contained within some of the care plans lacked sufficient description. If staff knew the person well, they would understand what the statements referred to, however, a lack of robust information could affect the way in which new staff or agency workers responded to an incident.

None of the care documents we looked at had been cross-referenced, such as the care plan with the risk assessment and follow up reviews. Risk assessments did not always explain what the risks were and how staff should support people to minimise the risks. We found that due to the way the documents were organised within the care plan, that it was difficult to find information. Staff told us they had access to the care plans, although it was 'difficult to read everything' due to time and how the care plans were organised.

The standard of the daily recording was poor and inconsistent. Some records were illegible due to poor handwriting. Other records contained a few lines describing the persons day as; sleeping, ate in the dining room and the time they retired to bed. There was a lack of information relating to how the person spent their day and their social interaction and positive outcomes. We spoke with the manager regarding the quality of the daily records and they told us that it was variable due to the number of staff who completed the records. They were intending to provide record keeping training for staff.

People's care plans were reviewed on a three monthly basis. The reviews we looked at were brief in content and did not give an holistic overview of the person's care and treatment. There was a lack of information on what had changed for the person, what had improved or how the person had progressed and what the expected outcomes for the future were. In addition, there was a lack of consideration of the psychological welfare of the person.

We reviewed a log of social activities which gave a list of the people who had attended an activity with a brief description of the activity. There were a considerable number of entries saying 'No attendee's' but nothing to say why people had declined. Within people's care records was an activity sheet to document what activities or social interaction people had taken part in that day. The activity sheets either had a one line entry or were blank. There was a lack of review and assessment regarding the impact of the activities and the outcomes for people who took part, especially for people with a dementia where a lack of meaningful occupation could significantly impact on their overall well-being and behaviour.

Inadequate

Is the service responsive?

This was a breach of Regulation 17 (1) (2) (b) (c) Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about the complaints policy was available to people and their families. The home had received complaints regarding the quality of care and staffing levels. We saw that the staffing level had increased following one complaint. We spoke with relatives about the communication between staff and families. They told us "there has not been good communication with the home and it is particularly poor with the continual changing of managers". Relatives gave examples of what they considered to be poor communication such as, where they had missed being able to speak with the GP despite requesting that staff inform the GP that would like to meet with them. One person had a fall and the family did not find out until they rang the home. There had been issues with the laundry, but this was better now with labels supplied by the home, but we were told that the home had now run out of labels. A family raised the issue about a TV in their family members room which had not worked properly since they moved into the home in December 2014. They had raised this with 'a succession of managers' and it was still not working properly. We spoke with the manager regarding this issue and they were not aware of it.

The activity co-ordinator was new to the role and was still finding out what hobbies and interests people had and how they would like to spend their time. During the two days of our inspection we saw people took part in activities within the home. People sat out in the garden, some were gardening. The activities co-ordinator held an exercise class and there was a session on a clue and answer activity which 17 people took part in.

We asked people what they thought of the activities and social events which the home provided, people told us 'it would be nice to have more entertainment from outside – we used to have more but its less now. I like the exercises but I can be a bit lazy". "It can be annoying when the programme is changed at the last minute". 'I'd like to be able to get out and buy a few things, it's nice to get out of the room". People chatting at lunch time told us "I'd like to go to M & S, oh yes that would be nice, I would like to go just for something to do. Have you ever heard of Clarke's village, oh but you need a car to get there though". People told us what they thought of the activities offered, one person said "we had someone come and talk about 'rugger', who's interested in rugger?" and "I like music, we should have more of that, not the modern stuff – I like classical music".

People's individuality and characters were acknowledged by staff who knew the likes and dislikes of people well. People's preferences were supported by staff. There were set times for meals and people told us they could have a snack or a drink whenever they wanted. People could choose to eat in the dining room or in their own room.

People's rooms were individualised; they commented on how they were encouraged to bring in photographs, ornaments and small items of furniture and memorabilia from home and were able to arrange the room as they wanted.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection on 7 and 10 August 2015, the provider did not have a registered manager in place. It is a condition of the provider's registration that they must ensure that the regulated activity of accommodation for persons who require nursing or personal care is managed by an individual who is registered as the manager in respect of the activity as carried on at Wiltshire Heights care home.

The home had been without a registered manager for nearly a year. The last registered manager left their employment at Wiltshire Heights care home on 11 August 2014. Since that time, two experienced managers had been employed; however, both terminated their employment with the provider and did not make an application to become the registered manager. The deputy manager had recently terminated their employment with the provider.

This constitutes an offence under Section 33 of the Health and Social Care Act 2008.

Following an inspection of Wiltshire Heights Care Home on 13 August, 18 and 17 July 2014 we found the provider was in breach of regulation 10 of the Health and Social Care Act (regulated activities) Regulation 2010, Assessing and monitoring the quality of service provision. There was no formal process to ask people and their relatives for their views about the quality of the care provided. The home sent an action plan to tell us how they were going to address our concerns. They were going to send out a questionnaire to all people living in the home and their relatives in order to provide feedback on the quality of the service provided.

At this inspection we found that the home had not addressed the issues identified on 13 August, 18 and 17 July 2014 in relation to finding out peoples and relatives views on the quality of service provided, and using this information in order to improve services. The manager told us they had not sent out questionnaires but would be doing so. They did however, have comment cards which people could complete.

There was a lack of clinical leadership and lines of accountability on the nursing floor. The manager in place at the time of our inspection did not have a clinical background and there was a lack of support to nursing staff and monitoring of care practices. The regional manager told us that nursing staff were able to contact a lead in one of their other care homes who also visited the home to offer support. We spoke with two registered nurses who told us they would ask the district nurses for advice and support. An exit interview for a nurse who had left their employment stated they had not received the support they expected to have.

During our inspection we asked the manager to provide us with the stock ordering sheets of the medicines for the nursing floor. The manager was not able to provide us with the ordering sheets. They stated this was because the member of staff who ordered the medicines was on annual leave. This demonstrated a lack of organisation in ensuring that more than one member of staff was aware of the ordering system and a handover took place when staff went on annual leave.

As part of ensuring that people were safe, we looked at the staff files of new employees to check they had a current Disclosure and Barring service (DBS) in place and that the provider had authenticated their last employment through a reference. We reviewed the interview and application details of one registered nurse. The provider had not requested a reference from the manager of the last employer, although these details were on the application form. They had however, requested a reference from a nurse associate at the last employment. We asked the manager if they had received a reference request from the nurse's new employer. They told us they had not. This demonstrates that the provider had not taken all possible actions towards ensuring that the person employed was suitable to work at the home.

The quality assurance systems and processes in place did not ensure people's safety and well-being. The systems in place used to assess, monitor and improve the quality, safety and welfare of people were not fully effective. Some audits did not identify where standards were not met. The medicine audits did not identify for example, errors in recording or medicines not being in stock. Likewise, the care plan audits did not identify the issues which we found and the shortfalls in recording.

There were no clinical audits of the 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms to ensure they had been completed in line with current legislation and the decisions made were appropriate and lawful.

Inadequate

Is the service well-led?

We reviewed the audits for falls, incidents and accidents. The monthly audits gave a breakdown of the number of falls, incidents and accidents. However, the information had not been analysed at an individual level or at a service wide level, to highlight the trends and patterns which would enable the provider to reduce potential risks to people.

This is a breach of Regulation 17 (1) (2) (a) (b) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said the manager was approachable and they had an open door policy. A member of staff said "staff morale has improved, it's so much better and residents are a lot happier". Another member of staff told us "the provider is open to training, it's very good, we have regular staff meetings and staff are a lot more settled, feel we can talk to the new manager". Staff felt the approach of the provider and the manager was open and transparent. A relative told us things had improved with the new manager, especially around staffing.

The manager told us they visited each floor to review staff practice and staff confirmed this. A member of staff told us "we want to look after people and go home with a smile knowing they are happy. They trust us and we have a good relationship with them. It's a good team and we all get on. We do get a thank you from the manager for the work we do, that makes us feel appreciated".

To ensure the night staff felt part of the team, the manager told us they visited early in the morning to talk with the staff, have meetings and carry out supervision. The manager also visited the home on weekends for unannounced visits as part of their quality assurance. At the time of our inspection, the manager had been in post for three weeks and had previously provided managerial support when required throughout the year. They told us they felt very supported by the regional manager and had peer support from the managers of the providers other homes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Mental capacity assessments were not carried out in accordance with the Mental Capacity Act 2005. The process of deciding capacity for decision making had not been followed with regard to 'Do Not Resusitate' orders. Deprivation of Liberty Safeguards were not completed as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not always receive appropriate support to eat and drink, choose their meal and have access to specialist equipment to promote their independence when eating and drinking. Some items of food were cold. People were interrupted during their meal time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records of people's care and treatment and decisions taken in relation to their care and treatment provided were not kept securely. The care records did not accurately reflect the care being provided or required. The quality of recording was inconsistent. Some sections lacked sufficient detail, had incorrect information or did not give adequate explanation.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy was compromised as not all staff waited for a response to be invited in, when they knocked on people's doors.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk of receiving inappropriate or unsafe care or treatment due to a lack of planning, assessment, monitoring and evaluation of their needs. The provider did not do all that is reasonably practicable to mitigate such risks. People could not be assured that persons providing care or treatment had the competence, skills and experience to do so safely. Staff had not completed the medicine administration records, to show they had administered people's medicines as prescribed. Protocols were not in place for medicines to be taken 'as required'. Service users did not have access to the equipment they needed, not all staff were knowledgeable about the equipment in place and staff did not monitor if the equipment was being used appropriately. There was a lack of consideration for the organisation of the management of medicines and ordering.

The enforcement action we took:
We issued a warning notice for breaches in Regulation 12 (1) (2) (a) (b) (c) (e) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.