Sandown Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 24 and 28 November 2017 and was unannounced. Two inspectors and an expert by experience in the care of older people carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Sandown Nursing Home is registered to provide accommodation for up to 39 older people. There were 33 people living at the home at the time of the inspection. The home is a large extended property and accommodation is arranged over two floors, the ground floor offering dining and lounge areas and bedrooms. The first floor had further bedroom accommodation. The majority of bedrooms were for single occupancy and had ensuite facilities. Bathrooms and toilets were provided on both floors. There was a lift and stairs available to access the first floor. There was level access to a patio and garden area.

Sandown Nursing Home is a 'care home'. People in care homes receive accommodation, nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be clean and well maintained throughout the inspection.

A registered manager was in place. 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.

A previous inspection of the service in November 2016 had identified that the service had breached regulations in relation to infection control and medicines management. Improvements in relation to those breaches had been made.

At this inspection we found that there were not the required records in place to show how best interest decisions to provide care using restrictive practices had been made and discussed with relevant others as is required by mental capacity legislation. Systems in place to make sure the quality of service was monitored and reviewed had failed to address this issue.

The provider had arrangements in place to protect people from risks to their safety and welfare. Arrangements were also in place to store medicines safely and to administer them according to people's needs and preferences. People were supported to access healthcare services, such as GPs and community nursing teams.

Staffing levels enabled people to be supported safely and in a calm, professional manner. Recruitment processes were followed to make sure only staff who were suitable to work in a care setting were employed. Staff received appropriate training and supervision to make sure they had the skills and knowledge to support people to the required standard.

There were processes and procedures in place to protect people from the risk of abuse.

Care and support were based on plans which took into account people's needs and conditions, as well as their abilities and preferences. Care plans were adapted as people's needs changed, and were reviewed regularly.

Staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed. People and external health professionals were positive about the service people received.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs.

People found staff to be kind and caring. They were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's individuality, privacy, dignity and independence. Equality and diversity was seen to be actively supported with people being able to express themselves.

People were able to take part in leisure activities which reflected their interests and provided a high level of mental and physical stimulation. Group and individual activities were available if people wished to take part.

The home had an open, friendly atmosphere in which people, visitors and staff were encouraged to make their views and opinions known.

People received a varied diet of their choosing and meal times were sociable unrushed occasions. Infection control procedures were followed and the home was clean.

Risks to people were managed safely with plans in place to minimise risks where possible. People were supported and encouraged to be as independent as possible and their dignity was promoted. People were encouraged to maintain relationships that were important to them.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We found one breach 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of infection and staff followed best practice guidance for the prevention and control of infection.

Medicines and risks to people were managed effectively.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to restrictive measures, best interest meetings or discussions had not been recorded. Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made.

People received the personal and nursing care they required and were supported to access other healthcare services when needed. Staff worked well as a team and with external professionals.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

The environment and equipment were suitable for people living at the home.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff had a good awareness of people's individual needs and responded effectively when their needs changed.

People were offered a range of activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. People and relatives knew how to raise concerns and felt these would be addressed. There was a complaints policy in place.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

There were management systems in place to identify and manage risks to the quality of the service. However we found these had not addressed an area for improvement from the last inspection.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the management team.

The service had an open and transparent culture. People and relatives were kept informed and involved in the service.

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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 24 and 28 November 2017 and was unannounced.

The inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed information within the Provider Information Return (PIR) which was completed in November 2017. 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.

We spoke with eleven people living at the home and eight visitors. We spoke with the nominated individual, registered manager, general manager, three nurses and eight care staff. We also spoke with ancillary staff including, three catering staff members, an activities staff member, a maintenance staff member, an administrator and housekeeping staff. We spoke with three visiting healthcare professionals. We looked at care plans and associated records for seven people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Good

Is the service safe?

Our findings

At our last inspection, in November 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 as people were not always protected from the risk of infection. Staff had not always followed best practice guidance and infection control arrangements were not clear or robust. At this inspection, we found sufficient action had been taken and people were protected by the infection control procedures now in place.

Infection risks were managed safely. The home was clean and cleaning staff told us they had cleaning schedules to follow and enough time to complete all cleaning required. A hand wash basin was now provided in the laundry and appropriate procedures were in place for the laundering of soiled items. The laundry was clean and well organised.

The provider told us they assessed the level of cleanliness in the home when they visited weekly. They described actions they had taken when they felt one part of the home was not adequately clean. This had involved talking with staff to ensure they had the necessary time and equipment they needed.

All staff had completed infection control training and had access to equipment such as disposable gloves and aprons to protect themselves and people from the risk of the spread of infection. We saw this in use by staff when required. When people needed equipment for when moving around the home or when they required repositioning in bed individual equipment was available. We saw this within people's bedrooms. People had been supported to receive the annual flu immunisation which would help prevent the spread of this disease and antibacterial hand gel was available at the entrance of the home. A senior staff member was encouraging staff to also have the flu immunisation. The registered manager was aware of actions they should take if there was a potentially infectious outbreak at the home.

The local environmental health team had undertaken a food hygiene inspection. We saw Sandown Nursing Home had been awarded a five star rating, which is the highest achievable.

At the previous inspection in November 2016 we identified that there was no system to ensure people always received medicines with an appropriate gap between administrations. The registered manager had introduced an additional recording sheet to record the time these were given, meaning staff would know the earliest the next dose could be administered. We saw that these showed medicines such as paracetamol were being given in a safe way with an appropriate time gap between administrations.

Since the previous inspection in November 2016 the arrangements for the safe administration of medicines had been reviewed by the registered manager to help ensure these kept people safe. The registered manager told us in the Provider Information Return (PIR) completed in November 2017 that there had been errors in the administration of medicines. They told us they had completed an audit of medicines procedures and records and identified a need for greater monitoring of administration. Nursing staff administered all medicines at the home. They told us they now counted all medicines following administration to check records tallied with the stock levels. This meant any errors would be promptly

identified and helped ensure people received medicines as prescribed. One nurse said "Although it [stock check] takes time it's good, we are not making errors now."

People were happy with the arrangements to manage their medicines. One person told us they could ask staff for additional pain relief medicine if they had a stomach ache. They also told us staff always remembered their medicines. A visitor told us their relative had been commenced on antibiotics after a visit from the gp. They told us these had been started the same day they had been prescribed.

There were appropriate arrangements in place for obtaining, recording, safe storage of medicines and the safe disposal of unused prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. Nursing staff told us they had received training in medicines management and administration at the home in addition to that completed during their nurse training. We observed nursing staff administering medicines to people in a patient manner, and informing people what the medicine was for. They did not hurry the medicines rounds and we found the Medicines Administration Records (MAR) were well completed.

There was a procedure in place for the covert administration of medicines although nobody was receiving their medicines in this way at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. Nursing staff described the actions they would take if this were required. The procedure described would protect people's legal rights. It would ensure that all relevant people, including gp's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used 'as and when necessary' (prn) protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people.

People were protected from risks. Risks to people were minimised through the use of effective risk assessments, which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Individual risk assessments were reviewed on a regular basis with a clear summary of any changes made. This ensured nursing and care staff had up to date information about the person's needs. Where individual risks to people were identified, action was taken to reduce the risk. These included, for example, the risks to people of falls, choking, nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. The registered manager told us they had introduced a system whereby a nurse checked pressure mattresses to ensure they were being used correctly. We checked several mattresses and found they were being used appropriately. People were also assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments explained how staff should support each person to move. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance. We observed care staff supporting people using wheelchairs. The care staff were using the equipment appropriately and had put footplates on the wheelchairs before moving people.

We looked at equipment used to support people when moving and we saw evidence that the equipment was well maintained and serviced regularly. People confirmed they were supported safely when equipment was used. One person said "I'm hoisted. It's always two staff." They added "They tell me what they're doing, for example 'going up'." We saw that people had access to call bells so that they were able to alert staff if they required support. These were observed to be within easy reach throughout the home and in people's bedrooms.

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. For example, one person was at risk of falls and would step over a movement alert mat placed on the floor. The registered manager told us they had arranged for a physiotherapist to assess the person's mobility and a walking aid had been provided. The person remained at risk of falls so a door alarm was being used to alert staff the person was leaving their bedroom and ensure staff checked they were using their walking aid and were safe. Another person who liked to walk outside each day showed us their call bell and said "They [staff] gave me this small one as it's easier to carry." This meant should the person require support when out walking in the garden they could contact staff.

We identified one potential risk to the registered manager. The registered manager was aware of the risks posed by a fluid thickening powder if ingested without it being mixed with fluids. Individual risk assessments had been completed for people who required this. The risk assessment stated the powder should be kept out of the person's reach. We saw staff were following this and within bedrooms fluid thickener powder was not accessible to people. However, the risks posed to other people including visitors had not been assessed and arrangements put in place to manage the risk. One person at the home was living with dementia and independently mobile. They could therefore have entered another person's bedroom and placed themselves at risk had they tried to eat the powder. We discussed our concerns with the registered manager and senior staff on the first day of the inspection. The registered manager took action that followed best practice guidance provided by the NHS. The fluid thickening powder was moved and stored out of sight in people's bedrooms. Additional risk assessments had also been completed.

Systems were in place to ensure that when adverse incidents occurred lessons would be learnt to reduce the potential for repeat incidents. The registered manager reviewed all accidents and incidents, such as where people had fallen and considered additional measures that could be taken to protect the person. There had not been many falls or other incidents however, procedures were in place, such as those used to investigate medicines errors as detailed above, should incidents occur.

Environmental risks were assessed and managed appropriately. The general manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment and fire risks. Cleaning chemicals and other substances hazardous to health (COSHH) were stored securely. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, and had been trained in fire safety and the use of evacuation equipment. People had individualised evacuation plans in case of an emergency, which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and firefighting equipment was regularly checked. Contingency arrangements had been made should people need to be evacuated to alternative accommodation.

People told us they felt safe. One person said, "Yes [I feel safe]. The front door is downstairs and people can't just walk in." A visitor told us "I'm very happy with everything here. I'm sure she [relative] is safe." Another visitor said "No worries, I've never had any worries about safety". They and other visitors told us that when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relative was safe at Sandown Nursing Home.

The provider had appropriate policies in place to protect people from abuse. Staff had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. One staff member said, "If there was anything I was worried about I'd go to [name of registered

manager] or [name of senior staff member]." They added that they also knew how to contact CQC if they needed to do so. Another staff member told us, "We had training when I first started and I would go first to the matron or nurse. I'm sure they would sort anything out". The registered manager and the general manager took their safeguarding responsibilities seriously and worked closely with the local safeguarding authority to protect people from harm. The general manager had attended train the trainer training for safeguarding and was aware of how to access support from the local authority if this was required. There were notices around the home about the process for reporting safeguarding matters.

People told us there were enough staff to meet people's needs. People and visitors confirmed that staff responded promptly when call bells were used and they felt there were usually enough staff available. Staff responded promptly to call bells. During a busy time in the morning we saw call bells were answered promptly. One visiting healthcare professional told us, "The staff seem to know the residents well and I have never had any concerns about the safety within the home."

Staff told us their workload was "manageable" and we saw they responded promptly and compassionately to people's requests for support. Staff did not rush people and spent time ensuring they were settled and happy before leaving them. Staffing levels were based on the needs of people using the service. When setting the staffing rotas, the general manager took account of the skill mix to help make sure staff with the necessary qualifications and experience were available throughout the day. Absence and sickness were covered by permanent staff working additional hours, which meant people were cared for by staff who knew them and understood their needs.

There was a suitable and robust recruitment procedure in place to help ensure staff were suitable for their role. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions. Files for recently recruited staff showed all necessary checks had been completed.

Requires Improvement

Is the service effective?

Our findings

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

Some people living at Sandown Nursing Home had a cognitive impairment and were not able to give valid consent for certain decisions. This included the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people. We were told that the nurses carried out assessments of people's capacity and then if required would have discussions with the person's family and any other professional who may be relevant, to agree what would be in the person's best interests. Although we were able to see best interest decisions around general care and treatment, there were no written records of best interest decisions for restrictive measures such as bed rails and sensor mats, which alert staff to people's movement. We discussed this with the registered manager who said they would ensure this information was included when decisions to use such equipment were made. However, at the last inspection of the service in November 2016 we raised this issue with the registered manager who assured us that they would review the relevant documentation and ensure best interest assessments were formally recorded. This had not taken place as agreed. There was no record to show why it was in people's best interests to be cared for using restrictive measures and how these measures were the least restrictive option for the person.

The failure to ensure that, where people lacked the capacity to give informed consent, action was taken to comply with the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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 Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether DoLS applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLS applications had been made. There were systems in place to ensure that DoLS were reapplied for when necessary.

We saw that where people had made a Lasting Power of Attorney to manage their finances or to make decisions about their health and welfare, copies of these were kept in the home so that the nursing staff were clear who had legal authorisation to make decisions on behalf of people.

One staff member said, "We always give people choices/options, even if they lack capacity in one area they may still be able to make choices in others". Another care staff member said "We show people things to help them make choices. Like two different shirts to see which one they would like to wear." The activities staff member showed us their picture 'bank' which could be used to help people with communication needs or

those living with dementia to make choices about meals and activities. We saw staff offering people choices on a daily to day basis such as where they would like to sit in the lounge or what type of juice they preferred to drink. The registered manager was aware of how to access advocacy services should these be required. Care files detailed people's individual needs, showing consideration for their assessed needs and their personal preferences. Pre-assessments were carried out by nurses prior to people moving into Sandown Nursing Home. The registered manager told us that they considered if the home was able to safely meet the needs of people before agreeing to them moving in. They gave examples of when they had decided not to admit people whose assessments had shown the home would not be able to meet the person's needs. Care staff told us they had been provided with information about new people prior to them being admitted. They said this helped them to understand the person's needs and how they should be met. Care plans showed that relatives had been consulted during the pre-admission process. One relative said, "I was involved right from the beginning and if anything changes they let me know." The registered manager said they would consult with external health professionals already involved with the person's care as part of the pre-admission assessment.

Where people had specific needs in relation to their lifestyle choices we saw through interactions with care staff and care records that their needs were being considered and met. Care staff demonstrated a good understanding of people's needs and wishes. For example, they told us how they supported people's human rights, how individual people like to be supported and what was important to them.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. We joined staff for a handover meeting between the morning and afternoon staff teams. This included nursing and care staff and ensured that relevant information was provided to the next team. People were seen regularly by doctors, opticians and chiropodists as required. A relative told us "[Person's name] wound care is good; they make sure [person's name] pain is managed and take as much time as they need." Another visitor said "He's had a period of not so good health and the doctor visited. If I'm not here they [staff] phone to tell me what the doctor said."

Sandown Nursing Home had equipment suited to the needs of people living there. The registered manager said they would only admit people for whom all necessary equipment was available and they knew how to obtain additional equipment if this was required. We saw that where care plans identified a need for equipment this was available for people. Nursing and care staff were able to describe the action they would take should a range of medical emergencies occur such as a person choking or showing signs of a stroke. They confirmed they had received training for such situations. Systems were in place for staff to receive urgent support from other staff if required. We saw staff responding quickly when an emergency bell was used during the inspection. We spoke to external health professionals and one told us, "The registered manager (matron) is excellent and a real asset to the home". Another told us, "They [the staff] are very friendly, approachable and seem to lead the team effectively".

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "The food is very good here". A relative told us "[Person's name] only eats small amounts but the staff here are amazing with [person] and go at their pace, they don't rush." People received the appropriate amount of support and encouragement to eat and drink. Many people required full support with all meals and drinks and we saw this was provided patiently. Care staff said they had sufficient time and did not feel they had to rush people with their meals. A catering assistant was employed. They explained their role also included assisting people with drinks and meals. Care files had clear information about any special dietary needs people had and if they required a soft diet or needed support to eat. There was also clear information about the food and drinks that people liked and did not like. Records viewed

showed people were receiving appropriate food and drink. Where people were reluctant to eat and drink external health professionals were consulted. Nutritional supplements were provided when necessary.

One person was receiving their nutritional needs via a tube directly into their stomach as they had been assessed by the Speech and language Therapists (SaLT) as not being able to safely swallow. Their care plan contained information from the dietician as to how their nutritional needs should be met, including the amount of fluid they should receive each day. Records showed they were receiving the correct amount of fluids and nutritional prescription although this had not always been added up correctly. The registered manager said she would remind staff of the need for greater accuracy in this respect.

People had a choice of what they wanted to eat each day. There were usually two choices but the chef told us they would make an alternative if someone requested something or did not like the options offered. Meal times were spaced evenly throughout the day but people told us that if they asked the care staff they could have food when they wanted. Fruit, cake and biscuits were readily available at all times. People who had lifestyle and religious choices about the food they ate were respected and their choices adhered to.

The environment was appropriate for the care of people living at Sandown Nursing Home. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. This would help people to settle in and feel at home. There was a spacious and bright communal lounge with several separate areas and a bright dining room. People could access the garden which was level and suitable for those with limited mobility. There was a choice of several bathrooms or shower rooms, suitably equipped to support people with high care needs and located close to people's bedrooms. A maintenance staff member was employed. They told us any staff could inform them of minor repairs that were required and gave us examples of tasks they had completed during the inspection. External contractors with the relevant qualifications were used when required, for larger or specialist jobs.

People were cared for by staff who were appropriately supported in their role. All staff received regular one-to-one sessions of supervision. These were organised to provide supervision of staff practice, e an opportunity for a discussion about training needs and concerns, and to offer support for the staff member. Staff who had worked at the home for over a year had received an annual appraisal to assess their performance and identify development objectives. Staff confirmed they received supervision and spoke positively about the support they received from the management on a day to day basis.

People were supported by staff who had received an effective induction into their role. This enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff. Newer staff confirmed they had received an appropriate induction, including shadowing experienced staff members and formal training. This included the Care Certificate which is a set of standards that health and social care workers adhere to in their daily working life.

Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service. Care staff were positive about the training they received, which was a mixture of computer based learning and in-house practical training, such as for moving and handling and first aid. They were also able to access external training if needed. Nurses were linked with the local NHS hospital and accessed all necessary training to ensure they kept their nursing knowledge up to date and maintained their professional registration. We observed staff applying the training they had received. For example, we saw staff supporting a person appropriately to transfer from their chair into a wheelchair using moving and handling equipment. The equipment was used correctly. People felt that staff knew how to look after them. One person said "They know what they are doing".

Staff worked collaboratively for the benefit of people. We spoke with ancillary staff who told us they had completed the same basic training as care staff including emergency training, meaning that they would be able to assist other staff if required, such as during a fire. We saw the registered manager led by example and undertook all tasks that required doing. We saw them assisting a person with their meal at lunch time. One person told us "If a couple of carers are off sick then the nurse will help." Care staff confirmed this and said they felt able to ask nursing staff for assistance if another care staff member was not immediately available. The general manager told us that Sandown Nursing Home did not use agency staff and were able to use the existing staff team to cover the needs of the home. They told us that staff team were flexible and would fill in when needed. We observed staff members working together to ensure the effective delivery of support to people. One staff member told us "We work as a team, it's a good place to work, we work together well".

Good

Is the service caring?

Our findings

People were positive about the way staff treated them saying that all the staff were kind and caring. A relative told us. "It's very good here, I don't think I'd find better anywhere else". A person said "The staff are very friendly, always have a laugh and a joke, if you want anything you ring the bell and after a few minutes they're here." We saw staff spend time to make sure another person was settled and comfortable in the lounge before leaving them. A staff member was observed saying to a person, "Here's your bell and drink, and here's your bag."

We observed staff throughout the inspection and found they were caring, patient and kind. Staff spoke to people in a respectful but friendly way, taking their time to ensure the person had the time they needed to understand them, where possible. We saw the registered manager talking to people throughout the inspection and demonstrating an understanding of people's individual needs and preferences. Staff were supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with kindness and compassion. An example of this was, "Right, there we go my darling, are you ready?" A second staff member said, "Hello, I've got your lunch here for you; here we go I will just give you the first mouthful now." This ensured that where people were being supported to eat in their own bedrooms or individually in communal rooms, they enjoyed a social occasion rather than a task being completed.

We observed care staff checking if people needed anything and enabling people with communication difficulties to have time to process information. Staff interpreted people's needs by offering options clearly and waiting for people to answer through verbal answers or body language. For example, a care staff went up to a person sitting in the lounge area, they sat with them quietly whilst visually checking if they were alright and offering a drink or to use the toilet. One person told us "It's very good here and the staff are all lovely and everyone is helpful". A family member told us "I am so relieved [person] is here, the staff here are great. I feel [person] is being well cared for and all their needs are met." People's rooms had their own personal belongings in and were kept clean and tidy. They had their own toiletries and any personal items they wished to have with them.

People's lifestyle choices were respected and details of how they liked to be supported were contained in their care plans. Details about people's religious needs were included in care plans and where people had particular needs information about how these should be met. One person told us how much they loved Christmas. They said they had mentioned to staff that they usually put their tree and decorations up early. Staff had responded by putting up a tree in the person's bedroom which we saw during the inspection. The person was very happy with the actions of the staff. Staff told us about people's needs and were aware of their rights under the Equality Act. When talking about people staff demonstrated they respected diversity and treated people in a kind and caring way, whilst adhering to any individual needs or wishes people had about their lifestyle choices. People were supported to stay in their rooms or attend the home's communal areas if they wished to do so.

We observed a handover between the staff from one shift to another. The language used when describing people was kind, respectful and person centred. Staff described how they had supported people's individual

choices such as when people had requested not to receive care at a specific time. Subsequent staff said they would offer the care later in the day. Both male and female staff were employed. Where people had a preference to receive care from staff of a specific gender this choice was met. Staff were able to tell us which people had a preference. They described how they would "swap" care staff around to meet these requests. A person said "Usually it's the ladies who wash me. I don't like the men." All care staff at the handover meeting knew people well and showed care and compassion when discussing their needs. Sandown Nursing Home allocated a named member of staff as a key worker for each person. The registered manager said the role of the keyworker was to "Ensure the person felt 'special' and make sure they had everything they needed."

People had 'social activities' care plans in their care files which detailed things they enjoyed doing and things that they didn't like. It also described how to support individual people with different activities. The care plans contained detailed information about what each person's personal history was, what they were interested in and who their family members were. Any religious or cultural needs were recorded and the general manager told us that they respected people's individual beliefs and would arrange for religious leaders to visit the home if people wished.

Staff protected people's privacy and dignity at all times. People confirmed their privacy was maintained by nursing and care staff when they were receiving personal care. A visitor said "If I arrive and the door is closed I know they [Staff] are doing some sort of care, they always close the curtains and door." From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said "We use large towels to cover the parts [of people] we don't need to expose." We saw staff knocked and sought permission before entering people's rooms.

Although most people were frail and dependant on staff people were supported to maintain relationships and to be part of the local community. We observed visitors coming into the home throughout our inspection. One person told us "Visitors can come whenever they want." Visitors told us they could bring children to visit and we saw this occurring during the inspection. One visitor told us they were able to bring in their pet dog which their relative loved seeing. Some people did not have regular visitors. Therefore a charity for older people had been approached and were providing visitors for these people. This showed an understanding of the importance of providing people with contact with the world outside the nursing home.

People, and when appropriate relatives, were involved in care planning and reviews of care. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said, "A few weeks ago I met with the doctor and the matron. They made sure I was aware of the changing situation." Another visitor said of the staff, "They [staff] call me if anything happens". A third relative said "We have access to the folder in [person's name] room. It gives us lots of information, fluids, dietary – what she's eating, care that has been provided, how she is." The relative identified this was good as it helped them know the person was being well looked after.

Where appropriate, relatives were supported to continue to provide some care for their loved one. We saw a visitor supporting a person with their lunch showing that they were enabled to maintain their relationship and feel that they were involved in the care of their relative. Staff also cared about people's visitors. We saw staff welcomed many visitors by name and asked how they were. We saw visitors were offered refreshments and staff ensured they were comfortable when visiting. The chef told us visitors were able to receive a meal with their relative and that they always made birthday cakes to ensure special occasions were celebrated.

Care files were stored in the nurse's office, which was in sight of the main lounge. Paper care files were stored in a lockable filing cabinet. Where care related records were recorded using an electronic care planning system, there was a log in and password for staff to access. Care information was kept confidential and the office door was locked if no staff were in the area.

Good

Is the service responsive?

Our findings

People and their relatives were happy with the way Sandown Nursing Home met people's personal and care needs and told us care staff knew their preferences and respected their wishes. A visitor told us, "He's well looked after." Another visitor said, "They're [staff] good and look after [name of person] well." The visitor added "They [staff] are all excellent."

Staff were flexible to meet people's preferences as to how and when their care was provided. For example we heard care staff informing the registered manager that a person was very sleepy so they would provide personal care later in the day. Another person was tired after lunch and staff assisted them to return to bed for a rest. We heard a person say they would like a hot drink and this was promptly provided. One staff member told us "We give people choices, anything they need we will do our best to meet their needs". They added "If people want something and we don't have it, we will pop out to the shop and get it for them when we can".

People's care plans were detailed and contained information about how they like to be supported and what help they required to meet health and personal care needs. For example, one stated '[Person's name] uses hearing aids but removes them. Staff to keep them clean and check batteries, reminding [person] to wear them'. Care plans described people and their particular preferences and lifestyle choices. They had clear information about what people liked and did not like. People and their families have been consulted to gather important individual information.

The management team conducted reviews of care needs and risk assessments regularly. Care staff had access to care files should they need to refer to these. Records of the care people had received reflected the information within care files. Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift, including information about the personal care people had received and if they had eaten and drunk well.

Senior staff told us how the service met individual needs and people's lifestyle choices. They recognised people's individual needs and preferences and tried to meet these as much as possible. We saw that there was a specific communication book for one person, which had large print days of the week, pictures and words, for example chair, bed, bath. There was also Makaton signing guide for staff. Makaton is a sign language that is used by people who have a learning disability.

When considering religious ceremonies in communal areas we were told that they consider the rights and wishes of others and found private spaces to enable preferences to be met without impacting on others. This meant those who wished to attend could, but those who choose not to were still able to access different communal areas of the home. One staff member told us, "There is a monthly service and we also have a Catholic priest comes to see a couple of people, about once a month. Another person has a specific religious belief and they have people from their group visit."

Most of the people at Sandown Nursing Home had high care needs and required the nursing care that was provided. Due to these high care needs residents meetings were not regularly held. The registered manager and general manager told us that they encouraged people and their families to speak to them about their views and tried to resolve any requests quickly. An annual survey was sent to the relatives and contacts of people so that the service could capture any improvements that may be suggested or resolve any concerns raised. There was a complaints policy and people and their families were made aware of this and how to raise a complaint at any time. We looked at complaint records and how these had been responded to. There had been no formal complaints made in the last year. When people or relatives raised informal complaints or issues, these were addressed. A person said if they had any concerns they would "Ask to have a word with [name of registered manager]." They added "I've never had to do that." A visitor said "No complaints." They added that if they had any they would talk to someone in the office.

People were supported to make choices about their preferences for end of life care and their families were consulted. Care files had information about people's next of kin and end of life details, such as the funeral provider people would want. An external health professional told us "End of life care is excellent – all nurses are trained in the administering of medication that may be required." Care files also contained other individual information, such as a person religious or spiritual needs and information about people and things, which were important to them. Care plans were regularly reviewed and alterations made. Nursing staff had attended training to enable them to better manage symptoms people may have at the end of their life. They were aware of how to obtain and administer symptom management medicines should these be required. An external health professional told us that they work together with the manager to review people's health needs within their care plans and ensure any medications required, available. The activities coordinator said, "I tend to sit with the poorly people especially if they haven't got family." The registered manager was aware of who they could contact for additional support if required. We were told that when people were at the end of their life and wished to receive a visit from a religious minister, the home had 'out of hours' contact numbers so this can be arranged at short notice if required. We were shown thank you cards which had been received from relatives thanking staff for the care that had been provided to people who had been receiving end of life care at the home.

People were happy with the activities provided. One person told us there were activities but they were "Not one for mixing. My television is my lifeline." They added that "If they've [care staff] finished their work the girls [care staff] come in for a chat, they're good to chat to." Another person said "They have some music, [name of activities coordinator] runs it, but I've never been one for music. I do puzzles and colouring. I'm quite happy." People were supported to take part in activities and we saw an activities board, which had many photographs of the activities and events that had been held at Sandown Nursing Home over the last year. Examples of this were photographs of birds of prey being brought in for people to see and touch and also donkeys and guinea pigs. The management team told us that staff had volunteered to support some of the events in their own time. The home employed an activities coordinator who organised activities in small groups or individually depending on people's needs and wishes. They adapted the activities offered to meet the needs of the people and would often provide individual activities in people's bedrooms if they either choose to or were unable to participate in the communal areas. They told us "We planned painting this morning but it's darker so a few [people] go back to sleep and some are chesty so I'm doing more 1:1's today." We saw these activities included reading to people and giving nail manicures.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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 registered manager was a qualified nurse who regularly works as a nurse, providing hands on care for people. They identified that this helped them understand the pressures felt by other staff and ensured they knew people and relatives.

Although people and visitors were happy with the care provided and felt the home was well run we identified an area where improvement had not been made despite it being raised as a concern during the last inspection of the service. At the last inspection in November 2016 the registered manager was made aware of the requirement to comply with legislation designed to protect people's rights and freedoms. The registered manager had advised the commission that they would undertake the necessary assessments and record these as required by the Mental Capacity Act 2005. However at this inspection we found that the registered manager had failed to record why restrictive measures were in people's best interest. The provider governance systems had not ensured this necessary action was taken following the last inspection. We observed that although the registered manager had taken a proactive approach to raise standards in relation to past breaches of regulations they had not ensured that this area was addressed. This has resulted in a new breach of regulation.

People and relatives were happy with the service provided at Sandown Nursing Home and felt it was well managed. A person said "I don't think I'd find better anywhere else." Another person said "I find things are marvellous here." One visitor said "I'm pretty happy with it here." Whilst another visitor said "It's very good here." People and visitors felt able to approach and speak with the managers and were confident any issues would be sorted out. Many people and visitors were able to name the provider, general manager and registered manager, showing that the management team made sure they were available to people and visitors.

The registered manager and general manager told us their main challenge was in recruiting new staff members but they now have a nearly full complement of staff, including a new deputy manager. We were told that they have had some staff sickness but have been able to get part time workers to cover shifts. This has meant they have been able to cover shifts from within the existing staff team so people were cared for by staff they knew well. This also showed staff were committed to the service. Staff members told us they usually all got on well together. One staff member said there had been some 'personality issues' but that things were now much better. A person told us, "They're [staff] a good bunch, all the staff, they're always laughing and joking, you never hear them argue."

There was a clear management structure in place consisting of the provider, who took an active role in the running of the home, a general manager, a registered manager and a deputy manager. Each member of the management team had specified responsibilities, which allowed the provider the time and space they needed to take an overview of the service and monitor its performance. A duty manager system was also in

place to enable staff to seek support and advice out of hours. Staff meetings were held, providing an opportunity for the management team to engage with staff and reinforce the service's values and vision. The registered manager told us that they felt well supported by the provider. The provider described their goal as being to ensure the service was one they would be happy for a member of their own family to receive care in.

Staff spoke positively about the positive open culture and management of the service. They said they were able to raise issues and make suggestions about the way the service was provided and their suggestions were taken seriously and discussed. Staff told us they felt supported and one staff member said, "I don't need to bottle things up I can just go to them (management)." The general manager's office and the registered managers office were both located on the ground floor and were easily accessible to people, staff and visitors. The registered manager was observed talking to people and visitors and was visible throughout the inspection should people have wished to talk to her. The home had a positive culture that was person-centred and open. The management team and staff demonstrated that they had a well-developed understanding of equality, diversity and human rights in order to provide safe and compassionate care.

The home had a whistle-blowing and safeguarding policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary. The provider and the registered manager understood their responsibilities and were aware of the need to notify the CQC of significant events, in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

The home had governance, management and accountability arrangements. We found that the registered manager and the general manager addressed incidents and concerns quickly. They told us that they would speak to the people raising concerns and try to resolve things to the satisfaction of all involved. Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood their responsibilities in respect of this although they had not needed to follow the procedure as no significant incidents had occurred. Relative's views about the service were sought through an annual survey and the managers told us that they speak to people all the time and quickly act on any concerns or wishes expressed by people living at Sandown Nursing Home.

There were a variety of audits for the maintenance and safety of the home that had been undertaken by the registered manager and general manager. Where these had identified areas for improvement we saw that action had been taken. For example, medicines audits had identified a need to improve the systems in place. As a result additional monitoring of medicines was now occurring and records showed people were receiving their medicines as prescribed. However, the managers recognised a need to further improve the quality assurance systems which they identified were not always effective. They had arranged for a bespoke audit process, using an external company to be set up. The home had a system for monitoring accidents and incidents and could identify any patterns that may require action to be taken. There had been no patterns that have required action in the last year. Sandown Nursing Home employed a full time maintenance person who was able to carry out regular tasks that were required, such as maintaining the building, décor and repairing or replacing anything as necessary. The maintenance person also carried out regular checks and monitoring of health and safety requirements within the home.

The registered manager and general manager told us they had developed links with the managers of other

local care homes through their membership of a local care homes association and attended meetings and conferences where appropriate. The general manager told us that they had signed up to receive newsletters and updates from national organisations that send information about any changes to legislation, care practices or safety information. They are also part of a local nursing homes forum with the local authority and the NHS clinical commissioning group for the local area. They were actively involved in being part of a new initiative to drive improvements across all care homes in the area. The general manager identified this would help them to continue to keep up to date with current best practice and to develop the service for the benefit of people.

There was an extensive range of policies and procedures which had been adapted to the home and service provided. This ensured that staff had access to appropriate and up to date information about how the service should be run. Folders containing policies and procedures were available to all staff at all times in the nurse's office.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person has failed to ensure that where people lacked the capacity to give informed consent, action was taken to comply with the Mental Capacity Act was a breach of Regulation 11 (1)