Jurvicka Limited

Sandhurst Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sandhurst Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. They provide accommodation with personal care to a maximum of 23 people. The home provides care for older people, some of whom are living with dementia.

This unannounced comprehensive inspection took place on 18 and 20 April 2018. It was carried out in response to the home being placed in Special Measures following an 'inadequate' rating at its last Care Quality Commission (CQC) inspection on 29 September, 4 October, 10 and 16 October 2017. There were seven breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the last inspection, we were in further contact with the registered manager and the provider. They assured us they wished to improve the service. We received a service improvement plan which logged the timescales that improvements would be made by. This was reviewed by the registered manager on an on-going basis and updates made.

We imposed a condition which required the provider to send us a monthly report of how they were addressing breaches of regulation and improving the quality of the service. These have been sent and been reviewed by CQC as part of our risk assessment for the service.

After the last inspection, Devon County Council took the decision not to admit any further people to the service and they reviewed the people living there. The provider agreed to voluntarily restrict admissions and to liaise with the local authority and CQC before they considered a new person moving to the home.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures. Following this most recent inspection, we judged this service had demonstrated improvement and had not been rated as inadequate in any of the five key questions.

On this inspection, some areas of management and auditing of medicines still required improvement. This meant there was a continued breach of regulation. However, the other six breaches identified at the last inspection had been met.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. In March 2016, this service was registered with CQC under a new legal identity; this is the second comprehensive inspection in connection of that registration.

The registered manager and the provider have not changed.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

At the time of the inspection, there had been a number of improvements. There was a more consistent approach to making applications to the local authority in relation to some people who lived at the service. People were now routinely involved in their assessments, care plans or reviews so their consent was gained. Documentation linked to lasting power of attorney for health and welfare was now requested. These practices meant people's legal rights were now better protected. Staff recognised further training would help them fully understand the MCA and make them more confident in their recording, such as in the case of best interest decisions.

Risks to people's health were better managed, for example monitoring people's fluid intake and weights. Lessons had now been learnt from an incident relating to previous poor skin care.

Improved recruitment practice ensured all the necessary information was now in place before staff started working at the home. Staff training routinely included practical training. This was in recognition that staff benefited from hands on training for some areas of care. Training had been extended to covered dementia care and end of life care in more depth. Staff practice supported people's dignity and privacy.

People were supported to see, when needed, health care professionals. Care staff recognised changes to people's physical well-being and visitors said they were kept well informed by staff regarding their relative's health and well-being.

Safety checks were carried out and the systems in place were more thorough although some action was needed during the inspection to address an unrestricted window and two unprotected radiators. Staff practice showed a better of understanding of infection control.

Staff had good relationships with people who used the service and spoke about them in a caring and compassionate manner. Visitors to the service praised the staff group and the registered manager. They were happy with the standard of care and the welcoming and friendly atmosphere. However, improvements were needed providing consistent meaningful activities and social events. A system had not yet been introduced to ensure activities happened regularly and met people's individual interests. However, an activities champion had been appointed who was keen to develop new ideas with the people living at the home.

The provider had extended their visits to the home and completed more detailed reports to show how they judged people were receiving good care and living in a safe environment. This was on-going work to ensure there was sustained improvement.

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a recommendation in relation to the environment and the Mental Capacity Act. We will meet with provider. You can see what action we have 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?

Requires Improvement

Some areas of service were not safe.

Medicines were not consistently managed or audited in a safe way.

Some aspects of the environment were not safe but were addressed during the inspection.

Improvements had been made to reduce people's health risks through better monitoring

Staff knew to report suspected abuse.

The recruitment process ensured people were cared for by suitable staff.

Infection control practice kept people safe from the risk of cross infection.

There was now a system in place to assess staffing levels; people were positive about the availability of staff.

Is the service effective?

Good

The service was effective

Increased staff training now provided staff with the skills and up to date knowledge to meet the needs of people living with more complex care needs.

People's legal rights were more consistently protected as deprivation of liberty safeguard applications were made in a timely manner. People or their representatives were now routinely involved in decisions around care planning and reviews.

People were supported to see, when needed, health care professionals.

People were positive about the quality of the food. Consideration had now been given to make mealtimes a pleasurable

experience.

Is the service caring?

Good

The service was caring.

People living at the home and their visitors were positive about the caring nature of the staff and the friendly atmosphere.

Staff practices respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

Most aspects of the service were responsive.

However, regular meaningful activities to motivate people and promote a positive well-being had begun but needed to be sustained.

There had been significant improvements to care planning.

People were confident their concerns would be acted upon and resolved.

Is the service well-led?

Requires Improvement

There had been some improvements to how the service was run but these needed to be sustained. Other areas need further work to ensure the management team were proactive rather than reactive.

There were new systems in place to monitor the quality of care provided and keep people safe, which needed to be embedded.

Environmental safety checks had improved.

The provider and registered manager were improving their audits of the service to ensure people were receiving safe and good quality care.

The registered manager was approachable and knew people living at the service well.

Sandhurst Residential 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.

Sandhurst Residential Care Home provides accommodation with personal care to a maximum of 23 people. The home provides care for older people, some of whom are living with dementia. When we visited 15 people lived at the home. The bedrooms are on three floors, which can be accessed by stair lifts.

Following the last inspection, we spoke with the provider to discuss the breaches and recommendations. The Care Quality Commission (CQC) also reviewed the Service Improvement Plan, which had been completed by the registered manager and the provider. This provided details on action taken and the dates this would be completed. Since the last inspection, a whole home service safeguarding process has been closed. This was because there were no new concerns and there had been improvements in people's care.

This unannounced comprehensive inspection took place on 18 and 20 April 2018. The inspection team comprised of two inspectors and 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.

A Provider Information Return (PIR) was completed in 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 reviewed the information included in the PIR along with information we held about the home. This included the previous inspection report and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We also reviewed information we received from health and social care professionals who had visited the service.

Following the outcome of our last inspection, the provider and the registered manager produced an action plan to address the breaches of regulation. Following enforcement action, the provider had to produce a monthly report every month to show CQC how they were monitoring the quality of the service.

We met all of the people using the service and spoke with six people about their experience of living at the home, and spoke with three visitors and relatives. We looked at five people's care including their care plans. Some people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with the registered manager and seven staff which included care staff, housekeeping and kitchen staff. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and staff files which included recruitment and training records. We also looked at quality monitoring systems used such as audits, checklists and monthly provider visit reports. CQC participated in multi-disciplinary meetings with health and social care professionals who had shared their views on the service. The last meeting was in February 2018.

Requires Improvement

Is the service safe?

Our findings

We judged people's safety had improved. This was because risks to people's physical safety and risks to their health were being managed better. However, there were still some issues which needed to be addressed linked to medicines management and the environment.

At the time of our visit the home did not have its own medicine policy. This meant staff did not have a guide for practice that was specific to the home, although National Institute of Clinical Excellence (NICE) guidance sheets had been downloaded on the advice of a health professional. The provider had contracted with a company to provide an electronic medicines system but staff said there were on-going problems with this system, which we reported on at our last inspection. For example, when we arrived in the morning staff were trying to administer medicines but the system was 'down' for 45 minutes. This meant staff could not see the medications for each person on screen and led to medicine administration taking longer than necessary. However, we checked the medicines which had been prescribed for administration at breakfast and saw these had all been given.

Staff told us this was a regular event due to areas where there was a low or no internet signal in the house. The registered manager had tried to address the issue by arranging for a new router to be installed. The registered manager said they had asked the provider to withdraw from the contract as they would prefer a paper based medicine administration record (MARs). Staff said this would make auditing stock levels easier and more accurate. Some staff were more confident than others using the electronic system.

Staff said audits had been presenting a problem due to the variance in staff understanding of the system For example, a senior care worker checked the medicine records of two people each week. Staff were confident there had not been any errors but the remaining stock records had not always been accurate due to staff having difficulty using the electronic system. Staff said what action would be taken in the event of a medicine error and what measures would be taken to prevent recurrence and share learning.

We checked a sample of liquid medicines and found none of the bottles had been labelled with the date of opening. The registered manager had reminded staff to address this issue in January 2018 in a team meeting. But this had still not happened when a pharmacist visited in March 2018 and also reported on this discrepancy. Their advice had still not been followed when we visited in April 2018. It is important to follow this advice as a number of liquid medicines have a limited 'shelf' life once opened which means their effectiveness could be damaged after this time.

We looked at the body maps for one person who was having a total of five different creams applied. Two out of the five body maps did not give any direction to staff regarding the frequency of application, they just said "as directed". This meant staff did not have appropriate guidance to identify what cream/topical lotion was to be applied, how often and where. We found a number of other people's body maps in the home with the same issue.

All these areas of concern were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

There were no covert medicines were being administered, no one was self-medicating and no one was receiving drugs that needed specialist storage, although secure storage was now available. Following our last inspection, staff now regularly checked the expiry dates of dressings kept at the home.

The medicine trolley was still positioned near to a radiator, which was noted at the last inspection but staff were now recording the temperature on a daily basis to ensure the contents did not overheat. During our inspection, they added the temperature guideline information, which was missing. The temperatures of the medicine trolley, storage room and fridge temperatures were recorded daily. There was a signature list for all staff who dispensed medicines. This is so that in the event of a medicine administration query the member of staff can be promptly identified.

Staff training for medications was provided by a national pharmacy on a face to face basis for two hours and records showed this had occurred recently. A total of nine staff administered medicines in the home. One person said "The staff make sure I take my medication on time." Night staff were also attending the medicines training; one member of the night staff booked a training session during our inspection. Staff were satisfied with the standard of training. Residents were registered with one of three local medical centres. Staff said medicine reviews where completed by the person's general practitioner (GP) on a six monthly or annual basis, which records confirmed.

The environment of the home had been made safer, for example there were no tools or cleaning fluids left unattended, which had been found on the previous inspection. Hot water temperatures were now measured in a consistent way. However, when checking windows, we saw there was a Velux window on a landing which was not restricted to reduce the risk of falls. We also saw two radiators in two different bedrooms had not been covered to reduce the risk of burns. Before the end of the inspection these risks had been addressed. Staff said one of the radiators had not been working for some time and staff had not noticed it was now too hot to touch; an electric fire had been fitted in the room which was covered. Incidents and accidents in the home had been recorded and action taken to reduce the risk of reoccurrence. However, this action was not consistently used to update the person's care plan.

Environmental risk assessments had been updated to provide guidance and direction for staff about how to support people and ensure care and treatment was provided in a safe way. A risk assessment had been completed in case the stair lifts were not working which now provided instructions for staff to action until the stair lifts were operational again. For example, how people would be supported with meals and personal care if they could not access the dining room or bathrooms.

The registered manager told us they carried out a weekly fire alarm test. Following feedback from us at the last inspection, they said they now visually checked equipment was working effectively. Fire records showed checks were made on a regular basis, for example, emergency lighting. There was now a list with people's names and room numbers to be used in the event of an emergency. There was also a log of where the fire extinguishers were kept making an audit of equipment easier for staff members. People now had an evacuation plan in the event of an emergency but these had not been personalised to recognise the different needs of individuals.

Improvements included the completion of risk assessments for nutrition and hydration (MUST), pressure damage, falls, moving and handling and use of bed rails. For example, records were up to date for people at risk of de-hydration and staff were observant and encouraged people and supported them to drink throughout the day. Where a risk had been identified there was clear and specific guidance for staff on how

to mitigate the risk. During the inspection, we met two people who needed a specialist mattress. The settings were accurate for each person's weight and records showed a person was being turned regularly. The community nurse team fed back how one person's pressure wound was improving and reducing in severity. Staff had undertaken further training in this area of care following the last inspection. People who needed them were sitting on pressure relieving cushions to help reduce a risk of damage to their skin.

Previous areas of concern which posed a risk to people due to a lack of effective infection control and prevention procedures had been addressed. Staff who worked in the laundry were confident there was no cross infection risk and were clear about how soiled laundry was managed. Staff practice showed their understanding of the purpose of protective clothing had improved. People had their own individual slings to prevent cross infection. There was a supply of cross infection control equipment throughout the home, such as gloves and aprons.

Recruitment practices had improved. Only one person had been recruited since our last inspection; their recruitment file contained all the necessary information required to employ a person safely. For example, they included the names of previous employers and the dates people were employed. A Disclosure and Barring Service check (DBS) was in place for staff members. The DBS holds information about people who may be barred from working with vulnerable people. When prospective staff came for interview, records were kept of their interview which had been improved since our last inspection.

The rotas showed there were generally four care staff on in the morning, which included a senior care worker. This reduced to three or four care staff in the afternoon, including a senior after 2pm. This reduced again to three care staff after 7.30pm. Since our last inspection, there were less people living at the home; the atmosphere was calm and unrushed. The registered manager had introduced a new staffing tool; during the inspection they acknowledged it was an important tool when new admissions occurred.

People told us they felt safe. One person said "It's the staff that make me feel safe, they are so kind." People in their rooms had accessible calls bells and knew their purpose, For example, two people said "I don't need to use my call bell a lot, but I know it's there if I need it" and "I don't have to wait long when I use my call bell, that makes me feel safe." People said staff were available and this was confirmed by people visiting the home. They said they were reassured by the stable staff team and said new staff were introduced. Staff wore name badges to help people identify them. Staff knew their responsibility to report abusive practice either internally or externally; they said there were no current concerns. A staff member said "I have a duty of care and one of my jobs is to make sure they are safe physically and emotionally. We monitor X who 'walks with purpose'. No one is going into other peoples rooms uninvited. We have three people ...who visit each other in their rooms."

Good

Is the service effective?

Our findings

At the last inspection, we made a requirement to improve how people's consent to support and treatment was gained. Steps to protect people's legal rights had improved although staff did not yet have a full understanding in relation to recording best interest decisions and staff decided to prioritise training in this area to further their understanding.

The Mental Capacity Act (MCA) 2005 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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager had made applications but none had been authorised yet.

Relatives were now asked to show legal documentation to confirm they were authorised to make certain decisions on the person's behalf. This indicated staff recognised people could not provide consent on the person's behalf, unless legally authorised to do so. Where people lacked capacity, there was better documentary evidence that people's capacity to make particular decisions had been assessed. One person had moved rooms and a record had been kept to show how this best interest decision had been made. However, best interest decisions were not always recorded and some staff were still uncertain about the process that should be followed to protect people's rights.

We recommend the registered manager ensures best interests decisions are recorded in a consistent manner and steps taken to build staff confidence around protecting people's rights.

Care records now showed how people had been consulted about their care. For example, care plans were signed by people living at the home who had the capacity to be involved in discussions about different aspects of their care. Some people living at the home had a diagnosis of dementia, their relatives had been asked to review the care plan and sign on their behalf when they had the legal power to do so. Staff told us how involving people with their care plans had produced a wealth of information.

Since the last inspection, staff training had improved with the support of external health and social care professionals. This meant staff had more sessions which were interactive and practical rather than purely computer based. A staff member said "I get regular supervision every two months and the training is really informative." This helped provide staff with the knowledge and the practical skills to provide care based on current practice. Staff gave positive feedback on how their training needs were now met. For example, a number of people at the home were living with dementia. Since the last inspection, staff had completed training in dementia awareness. We saw staff practice had improved with regards to pace of conversation and ensuring people understood before staff intervened. The registered manager told us how much they had learnt in a session on dementia awareness and they were keen to undertake additional training to enhance their skills further.

Following the outcome of the last inspection and the safeguarding process, the registered manager had recognised people's care needs were becoming more complex and staff needed training that gave them increased knowledge, confidence and skills. They had worked well with external professionals to ensure staff were encouraged and supported to attend training. Staff were confident with providing end of life care; they told us how they supported family members with their grief.
At the last inspection, it was highlighted how the environment did not enhance the independence of people living with dementia. Some basic steps had been taken to improve signage including signs for people's bedroom doors which were personal to them. Some people had been moved, with consultation, to rooms in the home which were less isolated. This was to help people find their rooms and enable staff to be more on hand to help them if they became disorientated.

We recommend the providers consult current guidance on the design of environments for people living with dementia.

We completed a tour of the home and visited most of the bedrooms. The standard of cleanliness of furniture had improved but one divan bed had brown stains on the side of the base. The registered manager was not sure how this had been missed and this was addressed before the end of our inspection. Visitors said they were happy with the standard of their relative's room.

Some people were able to tell us their health needs were monitored by staff and they had access to health care professionals if they needed them. Other people's relatives were positive about the staff group's skill in recognising changes in people's well-being and involving health professionals in a timely way. They told us staff kept them up to date. Since the last inspection, a new communication system had been implemented which had improved the sharing of health and well-being information between external health professionals and care staff. Records showed staff were quick to pick up on changes and during the inspection we heard them updating health professionals. Relatives told us staff knew when to contact them and update them. A person told us "If I'm not feeling well I know they will call for a doctor to see me."

As at the last inspection, people praised the quality of the food, which was home made. They said "The food is excellent " and "The food is very good." People who needed a particular style of food because of their health had their needs met. Visitors also commented positively on the standard of food and the homemade cakes. People were offered the choice of seconds and changes were made to respond to allergies or people's personal preferences. Staff knew people's likes and dislikes, which was demonstrated through their conversations with people. For example, how they liked their drink prepared. Since the last inspection, steps had been taken to make mealtimes a more pleasurable experience. New tablecloths had been bought, there were vases of flowers on the tables and condiments were available.

Good

Is the service caring?

Our findings

There had been an improvement in staff practice which promoted a culture that respected people's privacy and dignity. Staff remembered to knock on bedroom doors before entering. They were cheerful and friendly when they greeted people. Their practice showed how they respected people's wishes, checking with them before they intervened and being flexible to accommodate people's routines, for example offering lunch at later time to suit a person's preference. People said "All the staff are very polite" and "They always knock on my door before entering." Staff said "At the end of the day it's someone's mum or dad. We are respectful at all times."

On this inspection, staff were noticeably more conscious about where they shared information; care records were now kept in a locked cabinet which promoted confidentiality. They encouraged people to sit in more comfortable surroundings and took time to encourage people to participate in conversation when they recognised they were feeling low. A person, who had spent most of their time in the dining room at the last inspection, now sat in a comfortable chair in the lounge with a photograph of their family close by. Their care plan stated their family was very important to them. Staff used their family as a topic of conversation to engage with them and reassure them when they were anxious. Staff also understood the person's need for personal space and respected this in their interactions.

One person told us the badge they wore was very important to them; they said the staff needed credit for their caring attitude. They said staff looked after their clothes well and ensured the badge did not get lost. On their bedroom door, they had information about a charity which meant a great deal to them. They said they were pleased the charity's logo was on their bedroom door to help them recognise it.

Staff practice had improved in regards to their understanding of infection control so their practice was more respectful. This meant they no longer wore gloves inappropriately when assisting people to move or to support them with their meals. Staff were much more aware of how they informed people about meals and supported them. A staff member gently supported a person with their lunchtime meal. They explained what was on their plate and sat at their eye level and at an angle so they could have eye contact with them. They offered them a choice of cutlery and took their cues from the person. For example, it became clear the person was able to eat without assistance and was enjoying their meal. The staff member withdrew and explained to their colleagues why they had done this but monitored discreetly how the person was managing. This meant the person's independence was recognised and promoted. Staff celebrated with the person how they had recovered from an illness and were now gaining an appetite again and becoming more independent.

Staff had a caring approach. They said "I really enjoy it. I like caring for people it's like I am doing a good deed every day." Staff recognised when people's moods were low. The registered manager provided a strong role model due to their caring manner. They took time to listen to people's worries and sat with them to try and resolve them. Staff knew people well. For example, we asked staff how they would know if a person living with dementia was in pain. They were able to tell us that they would look at the person's body language, facial expressions and how they were mobilising. We saw staff picking up on people's changing

moods and changing their approach to accommodate them. One staff member had made sure a person was treated on their birthday which included a bottle of beer; they were aware the person would have no visitors that day and wanted to ensure the person felt people had remembered their birthday. The person said "It's my birthday today and they've made me a cake."

People looked relaxed in their surroundings and chatted to staff. They joked with staff and the registered manager and looked at ease. People were positive about their care. They told us they had a good relationship with staff. They said "Everybody is so nice" and "I get on with the staff very well." We saw numerous affectionate and caring staff interactions with people. Staff appeared happy and enjoying their work. Visitors said "The staff make us feel so welcome" and "The staff are just caring all the time." At out last inspection staff said they would like more time to sit with people. There were less people living at the home on this inspection, the atmosphere was calmer and staff did sit with people and engage with them more. People looked well cared for. Visitors to the home said they were happy with how their relatives were supported to maintain their appearance. People's clothing was hung neatly in wardrobes and generally packs of incontinence pads were stored discreetly to help maintain people's dignity.

Requires Improvement

Is the service responsive?

Our findings

The previous breach linked to person centred care has now been met due to extensive improvements in care planning and involving people in planning their care, including end of life plans. However, further work was needed to establish a consistent approach to meeting people's individual social needs.

Records showed that people's hobbies and interests had now been discussed and recorded. At the last inspection, staff said they would like to spend more time with people and to increase people's social interactions. As the number of people living at the home has decreased, staff said they had more time on this inspection to spend with people, including sitting with them in the courtyard and dancing with them. At the inspection, the registered manager said one staff had now been nominated to oversee social activities and become an activities champion. After the inspection, the provider told us how an activity would now take place on a daily basis. A new activities plan had been introduced and photographs had been taken to show how social activities had been successful, such as cake making. During the inspection, an event did not happen and staff were unclear why. The new role of activities champion should help ensure meaningful social activities become embedded in the life and culture of the home.

We asked people how they spent their time. Some said they preferred their own company and chose to stay in their room watching the television, listening to the radio, reading or meeting with visitors. One person was still able to go out independently. People had varying views on if there was enough to occupy them. People said "I'm not bothered about joining in activities, I like my own company", "I just like to read and watch television" and a visitor said "Mum just likes to sit in the lounge, but if there's anything going on she likes to join in."

The home's statement of purpose said 'Care at Sandhurst is service user based and so service users are encouraged to have an active part in their own care planning'. With the support of external health and social care professionals, the registered manager and the deputy manager had undertaken a lengthy piece of work to update and review all the care records. The provider had moved the deputy manager from care shifts to the office complete this work.

This work had taken time but meant care records were more individualised, up to date and reflected each individual person. Staff now understood the point of making care records meaningful and to engage with the person they were about. They said their goal was to now to ensure monthly reviews occurred and the current standard was sustained. The home's statement of purpose said 'Family and significant others are actively encouraged to take part in care planning'. On this inspection, this was an accurate reflection of current practice. This was confirmed by our conversations with people and visitors.

The care plans were person centred and contained pertinent information about the person, including a social and medical history and details of likes and dislikes. Treatment escalation plans had been completed. This is a document that details the person's wishes in the event of ill health. Staff were proud of the care they gave to people when they were dying and the support they gave to their family. For example, a staff member said if person was approaching the end of their life staff welcomed and supported their friends and

family. A large family, who had spent time at the home whilst their relative was dying, praised the staff for their "compassion and consideration."

Each person had a document called 'This is Me' had been completed, which detailed the person's past life experiences. The person and family members were also involved in the content of the care plan. Comments that had been written in the care plan were in evidence in people's rooms. For example, one person was described as loving flowers and chocolate and liked to have a beaker for drinks. We saw the person had a vase of flowers in their room, an open box of chocolates and a beaker of fluid on the bedside table. Another person had recorded in their care plan that they liked owls and the colour green. They had an owl artwork on their bedroom wall and a green armchair and the third person was recorded as enjoying blackcurrant squash and had a jug of blackcurrant squash in their room.

Since the last inspection, the provider had invested in an electronic care system to help improve recording and support staff. Staff were positive about its introduction, some were less confident than others, but training had been provided and was on-going. At the time of the inspection, daily records and risk assessments were recorded on this system. Staff said this provided them with a useful overview of how people's needs were being met and if their health and emotional needs were changing. They were concerned about the size of the task if all the new care plans had to be transferred over to this new system and planned to discuss this with the provider as they were concerned this would have a negative impact on their time to spend with people living at the home.

The registered manager recognised why improvements had been needed and said they knew it was their responsibility to assess people before they moved to the home. They said they had the confidence to request more information from health and social care professionals with planned admissions rather than emergency placements.

People told us about their preferences, such as getting up later and taking their time to shave in the morning. People's care plans held this level of detail and staff interactions showed they supported people's chosen routines. For example, proving a late breakfast. People told us they could get up and go to bed when they wished, which records showed.

The home's statement of purpose contained the home's complaint procedure, which contained timescales and contact details. Visitors were confident that the registered manager would address any concerns. None had made a formal complaint. Complaint information was available but was not clearly on display for people visiting the home.

We looked at how provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included people's sensory or hearing impairment. Staff knew people well were able to communicate with, and understand each person's requests and changing moods. The registered manager said there were photos available of food choices which would help some people living with dementia; they had not been used for some time but they decided to find them and implement them.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we identified two breaches of regulation in connection with poor quality assurance and not informing the Care Quality Commission (CQC) of notifiable events. Further work is still needed to embed new quality assurance measures but there have been improvements. The registered manager was clear when to notify CQC; this breach has now been met.

The mission statement for the service said 'We aim to be a successful and respected care home by putting quality first in everything we do, the quality of care and the environment we offer clients, the quality of our people their training and experiences and the quality of our food and activities on offer'. At the last inspection, we judged there was no effective governance or oversight of the quality of the care and support in the home and this had impacted significantly on people's safety, well-being and emotional needs. We imposed a condition which required the provider to send us a monthly report of how they were addressing breaches of regulation and improving the quality of the service. These have been sent on a monthly basis and been reviewed by CQC as part of our risk assessment for the service.

The registered manager and the provider had reviewed the way they audited the quality of the care at the home and the safety of the environment. There were some areas in these systems needing improvement. For example, the medicine audit had not identified issues found at the inspection, the environmental audit had not highlighted radiators that were not covered, a soiled bed base or an unrestricted window. Care plan audits did not recognise care plans had not always been updated and best interest decisions were not always recorded. Risk assessments had become more meaningful and effective but there were still some gaps so the approach was not yet consistent.

The registered manager responded quickly to a range of concerns that we highlighted during the inspection and was open to information that would help improve the service. This meant sometimes their approach was reactive rather than pro-active.

All these areas of concern were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider and the registered manager continued to work with local commissioners to improve the quality of care and the monitoring of the service. A number of health and social care staff had provided significant input to the service to provide support to improve. These professionals had begun to withdraw to enable the provider and the registered manager to demonstrate their ability to sustain and continue with the improvements that had been made.

On this inspection, we judged there had been a number of improvements, including in the standard of recruitment, environment, infection control, practical training, supervision and care planning. The current electronic medicines system still had on-going issues which negatively impacted on an effective auditing system.

The culture and the values of the service were now beginning to be assessed, monitored, and reviewed. Minutes showed staff meetings were taking place and the management of supervisions had improved to enable staff to express their views and offer suggestions to improve. However, these changes needed time to be embedded and sustained. Staff members were positive about the way they worked together.

Action had begun to formally gather people's views on their experience of living at the home. For example, sending out a quality assurance survey. There were not regular meetings for people living at the home to share their views; the last had been instigated by commissioners as part of the safeguarding process in December 2017. Subsequently, a letter had not been sent to people from the provider to reassure people living at the home and their relatives and update them on the improvements that had taken place. The registered manager said staff reassured and updated people on a day to day basis.

The provider continued to visit the home on a monthly basis but for longer periods of time. They had begun to implement advice from the quality assurance team from Devon County Council. This included expanding the areas they audited and recording them; we discussed with the registered manager how these would be improved further to provide a clearer audit trail. The report for the following month from the provider showed increased detail. However, some aspects of the environmental checklist needed to be improved to capture issues such as an unrestricted window. We also asked the registered manager to check the bedroom furniture for one person to ensure the height was suitable for their needs.

Previously the registered manager had not received formal supervision from the provider; since our last inspection one session had taken place. The provider was using the new electronic care system to audit the system when they were away from the service. For example, they had rung care staff to ensure a person had received the specific care they needed based on information from the system. This showed they were taking a more active role as the nominated individual and recognised their accountability to ensure people were safe and well looked after.

The registered manager and the deputy manager recognised the importance of making connections within the care industry and learning from others. They had made contact with another care home manager and were attending meetings to expand their knowledge.

People living and visiting the home continued to be positive about the friendly atmosphere of the home; one person said "Its lovely here, its home from home. I don't feel isolated and I get company. I love it here." People commented on the caring nature of the staff group and the registered manager. For example, "I hold the team at Sandhurst in the highest regard. I have been informed of Mum's situation at all times. The care staff are exceptional and when I talk to Mum she is extremely happy with her care, as am I."

People praised the approachability of the registered manager and the care staff. They said the atmosphere of the home was friendly and homely. They were confident the registered manager and care staff would address any concerns they might have.

Notifications had been made to CQC regarding people who had died at the home and who had sustained a serious injury. This meant CQC was able to monitor the operation of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine management required further improvement as did some aspects regarding the safety of the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit systems had been established but needed further work to ensure they identified areas for improvement in record keeping and the safety of the environment.