Bupa Care Homes (CFChomes) Limited

The Westbury Residential and Nursing 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?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The Westbury residential and nursing home is registered to provide personal and nursing care for up to 51 people. At the time of our inspection there were 44 people living at the home. The inspection was unannounced and took place on the 24 and 25 November 2015.

The service had a registered manager who was responsible for the day to day running of the home and had been in post for approximately two months. 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.

People received their medicines on time; however, medicines were not kept safe as the medicine rooms were unlocked at the time of our inspection. The medicine rooms were not kept within the required

Summary of findings

temperature to maintain the integrity of medicines and some medicines were not disposed of appropriately. The recording of medicines highlighted a lack of signatures on the MAR charts. There was conflicting information in the records around the application of creams and how often they should be applied. Protocols were not in place for all medicines prescribed to be administered as and when required.

People and relatives told us the staff were very kind and caring and we observed that staff treated people with respect and dignity. Staff were enthusiastic about their role and were dedicated to giving people a good quality of care. People received good care at the point of delivery although care records were not person centred.

The service did not follow the requirements set out in the Mental Capacity Act 2005 (MCA) when people lacked the capacity to give consent to receiving care.

Staff received some training; however, we found that staff had not received sufficient training in relation to the MCA, Deprivation of Liberty Safeguards, supporting people with dementia and positive behaviour management. Staff were supported through a system of supervision and appraisals.

People were able to take part in activities within the home if they wished to. People told us the food was good and we observed people were given drinks and snacks throughout the day.

People said they felt safe living at the home. Staff were aware of their responsibilities towards safeguarding people and showed a positive attitude to this.

There was a complaints procedure in place; the service investigated complaints and responded in a timely way.

People and relatives told us they did not feel there were sufficient numbers of staff at all times. The provider recorded call bell response times however this information was not fully analysed in order to ascertain the reason for long call bell response times. Some audits did not fully identify the issues we found.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Medicine rooms were left unlocked enabling people without the authority to enter them.

Some medicines were not being stored according to the manufacturers instructions and the provider policy.

People told us they felt safe living at the home.

Emergency plans were in place in the event of an evacuation of the home.

Requires improvement

Is the service effective?
The service was not effective.

There was a lack of understanding of how to implement the Mental Capacity Act 2005 and best interest decisions.

Staff had not received adequate training in relation to the people they cared for.

People told us they had enough to eat and drink.

Requires improvement

Is the service caring?
The service was caring.

People told us that they liked the staff.

Staff treated people with respect and dignity.

People and staff had developed positive relationships with each other.

Good

Is the service responsive?
The service was not responsive.

Care plans were not person centred as they lacked sufficient information about people's wishes and preferences.

People knew how to make a complaint if they wished to.

Ministers of different faiths visited the home to offer spiritual support and some people attended church with their families.

Requires improvement

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

People's information was not always securely locked away.

Staff felt supported by the new manager and were pleased with the changes made to the home.

Requires improvement

Summary of findings

People and relatives expressed concerns over the staffing levels as there were times they had to wait to receive care. The provider had failed to fully investigate this through analysing the call bell response times.

The Westbury Residential and Nursing 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.

The inspection took place on 24 and 25 November 2015 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of either using, or caring for someone who uses this type care of service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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 also looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern.

The Westbury residential and nursing home is registered to provide personal and nursing care for up to 51 people. There were 44 people who were currently residing at the home. During our inspection we spoke with 19 people and with ten relatives and friends.

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

During our inspection we spoke with the registered manager and the area manager, rehabilitation support worker, team leader, care workers, a nurse, kitchen assistant, the chef, a housekeeper and a maintenance contractor.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, looking at documents that related to people's care and support and the management of the service. We looked around the premises and observed care practices throughout the day.

Requires improvement

Is the service safe?

Our findings

The provider had a medicine policy in place to ensure that medicines were held securely and which stated 'access to medication storage areas should be restricted to those with designated medication management responsibilities or people with the right to access these areas'. The ground and first floor medicine rooms contained medical equipment and a medicine refrigerator which should be stored in a locked room to allow maximum security against unauthorised entry. Throughout the duration of our visit, the door to the two medicine rooms on the ground and first floors were unlocked and left open. The rooms allocated as the medicine rooms were also used as a nurses' station which meant that staff were continually coming in and out of the room.

As people and visitors to the home were able to enter the medicine rooms they were placed at risk of harm due to items of medical and other equipment being accessible to them. In the ground floor medicine room we were able to access scissors in a drawer and disposed of sharps [needles] in a yellow container. In the first floor medicine room, a cabinet was unlocked and contained supplies of dressings, insulin pen needles and needles for syringes, vacutainers, scissors and water for the use in injections. We reviewed the care records of people on the first floor and found that a potential risk for one person was being able to access sharp objects such as razors and scissors. The registered manager had not considered the risk of people having open access to the scissors or other items available. In the same medicine room were two large and three small oxygen cylinders yet there was no sign on the door to warn people that the room contained flammable materials. The registered manager had not ensured that the home adhered to the provider policy of the 'Management of Oxygen' by displaying a notice.

Some medicines and supplies were not labelled or had not been disposed of when they were no longer required. Loose dressings were not in boxes and we were therefore unable to tell who they were prescribed for. There was medical grade Manuka Honey which was prescribed for a person not on the list of people living at the home. In addition, in an opened cupboard we found fortisips and calogen drinks with some bottles not having a label of who they were prescribed for.

Medicines were not being stored according to the manufacturer's instructions or the provider guidance on the 'Storage of Medication'. We saw that some medicinal products were labelled 'do not store above 25 degrees Celsius'. The temperature recording chart for the first floor medicine room showed there were three occasions in September 2015 when no temperature had been recorded. On 12 occasions in September 2015, the room temperature exceeded the required temperature of 25 degrees Celsius with the highest being 27.6 degrees Celsius. In November 2015 there were nine occasions where the room temperature exceeded 25 degrees Celsius with the highest being 29.4 degrees Celsius. In September and November 2015, monitoring documents evidenced that the actions taken were 'fan put on', however there was no evidence of the outcome of this action. As the temperature variation had been found in September 2015 and had reoccurred in November 2015, then appropriate action had not been taken to ensure that medicines were stored in a safe and appropriate manner. This meant people were placed at potential risk of harm because extreme temperatures may cause medicines to deteriorate and reduce their effectiveness.

We found issues with where medicines such as bottles of Fortisip and Calogen drinks were stored and how staff ensured that stock was rotated so that people received drinks which were in date. Fortified drinks were stored in people's bedrooms, either under a chair, alongside the wall or in several rooms at the end of the bed. There was a lack of space in people's rooms for such bulky items which could increase the risk of trips and falls. For the items we looked at, the stock was not being rotated so that the oldest supplies were being used first.

Supplies of medical equipment were not stored appropriately. Outside of the lift on the first floor there were supplies of Ensure drinks, an empty sharps container, clean urine sample bottles and an opened packet of empty acutainer blood collection plastic tubes. These supplies were on the floor in the corner of the foyer and would be at risk of becoming unclean due to the packaging being opened and dust from the floor.

People were put at risk because of poor staff practice. On the first floor, during the morning medicine round, we observed members of staff and people interrupting the

Is the service safe?

staff administering the medicines. The member of staff did not explain to people they were administering medicines and were not to be interrupted. This practise could increase the risk of medication errors.

We looked at how the Medicine Administration records (MAR) were completed and found a range of errors including, a lack of staff signatures, conflicting information relating to instructions for the application of creams, details on MAR charts had been amended regarding the dose and frequency of some medicines without the consent of the GP. The process for recording the result of a warfarin test in the yellow book had not been followed as given by the provider policy on administration of medicines. There was a lack of PRN protocols in place for people. [PRN is where people have a medicine as and when required.] The provider procedure for medicines states that individual PRN protocols should be stored in both the care plans and alongside the MAR charts. This procedure was not being followed and could result in new or agency staff not administering the medicine in line with the protocol.

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

People received their medicines on time and we observed that staff were patient and enabled people to take medicines at their own pace. They explained what the medicine was for and offered drinks to people to take their medicine with. Nursing staff carried out weekly stock audits of medicines although the shortfalls we identified such as stock not being rotated had not been picked up. The registered manager told us they were currently working with the GP and pharmacy regarding more timely supplies of medicine; however at the time of the inspection each person had sufficient stocks of medicines in place. The drugs register for specific medicines had been completed correctly and two signatures were entered as required.

People told us they felt safe and liked the staff who supported them. A relative who visited five days a week said that “I feel XX is safe and well cared for and the carers are very nice”. One person told us “I feel safe here, [the person pointed to their call bell] but answering depends on how busy they are. Sometimes it is quick; while other times you have to wait quite a long while which isn’t nice if you need the loo quickly”.

During our visit we saw there was sufficient staff to support people in a timely manner. We received a mixed response when we asked people if there were enough staff working at the home to fully meet their needs. One person said “generally there are although on the weekends it does get busier”. Another person told us “getting up and going to bed is always difficult as staff are very busy, though nights can be better. I never see the manager and the lack of continuity of staff both nurses and health care assistants can make things difficult particularly for those who are a little more confused.” A third person said “staff are very busy here, and sometimes can be a bit short, but this is a poor excuse for not having enough staff. There have been times when I have not been able to get up [out of bed in the morning] because I have had to wait until staff are available”.

Most staff responded that they felt there were enough staff to deliver care and one member of staff said “it would be nice to have that extra time to just sit and chat with people”. Another member of staff said “sometimes on the weekends it can get very busy and we could do with a few more [staff]”. We discussed the staffing levels with the registered manager who showed us the call bell response times. They told us they actively monitored the staffing levels and ensured that the dependency banding was correct for each person. However, we found there was a lack of analysis being done to ascertain why the call response times were not being met.

Staff told us they had received safeguarding of vulnerable adults training and records confirmed this. All of the staff were able to describe the main factors which constituted abuse. Staff made reference to the provider safeguarding and whistleblowing policy and could tell us who they would contact to raise an alert. Staff told us they were confident that the registered manager would listen and act on any concerns they may raise.

Risk assessments were used to identify what action needed to be taken to reduce potential risks which people may encounter as part of their daily living, such as falls prevention, bed rails use and dehydration and nutrition. The risk assessments formed part of the person's care plan.

A variety of equipment was used by people to support their independence, maintain good health and ensure that staff could support them safely. Before using the equipment,

Requires improvement

Is the service safe?

care workers ensured that it was safe and fit to use. There were audits in place to evidence that faults were reported and checks were carried out for correct usage and wear and tear.

The recruitment processes in place ensured that new staff were safe to work with people. We looked at four staff files which evidenced that appropriate checks had been completed before staff commenced employement.

Business continuity plans were in place in case of an emergency such as a fire. In extreme weather conditions or with staff shortage, plans were in place to utilise staff from other services or to utilise staff that lived near the service. In extreme weather conditions staff would be given an option to stay overnight at the service to ensure continuity.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had not made all necessary applications to the statutory body for DoLS authorisations to protect people from unlawful restrictions on their liberty. We found there was a lack of understanding of how to put the MCA into practice. When people lacked capacity to decide on their care, the service did not always have specific assessments of capacity and best interest decisions in place to underpin the principles of the MCA.

There was a lack of understanding of restraint as defined by the MCA, for example staff did not identify that restricting people from leaving is a form of restraint as is giving personal care when clear consent has not been given by the person. We looked at the daily records of the care people had received. We found entries for different people where staff had made a decision regarding the delivery of care without sufficient evidence of a best interest decision having been made or of a DoLS being in place if they were prevented from leaving the home.

Staff told us they had to make a best interest decision if people refused personal care, for example, entries for one person stated '….(name) not at all happy with care being given'. The care plan also stated the person could be resistant to care and the person was to be given Lorazepam to 'ease their mood'. There was no best interest documentation as to the rationale for giving Lorazepam to the person in order to deliver personal care.

For this person and other people, documents were blank regarding how the best interest decision had been arrived at, what action had been taken to look at the least restrictive option, details of conversations with the person and why they may be refusing care.

Within the care records there was sparse information on how the provider had supported people to be able to make a decision. There was no guidance for staff on how to deliver or not deliver the care in the event that the person is resistant or refuses and that to give personal care without the person's consent could constitute a deprivation of their liberty.

Within the provider policy on restraint it states, 'The use of restraint without the consent of the individual concerned should only be considered where that person has a significant degree of diminished capacity to understand the risk that they are putting themselves and others at'. The provider policy on 'restraint' did not address the circumstances where a person refused personal care and maybe at risk of self-neglect and the appropriate agencies which should be involved.

During our inspection visit we spoke with staff about the MCA 2005 and DoLS. Staff told us they had received training in the MCA and DoLS, however, we found staff were not confident in explaining how this related to the people they cared for and two members of staff had not heard of the MCA or DoLS. In particular, we found that staff had misunderstood or were not aware of the processes involved when best interest decisions are required.

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

Staff had not received training relevant to the people they cared for. Some people who lived at The Westbury residential and nursing home had behaviours which may challenge others. On the first day of our inspection we were told by the registered manager the home 'did not do dementia care' and they did not have many people who would fall into that category. During our review of people's care records we found that at least nine people were recorded as having dementia with or without a diagnosis,

this included Alzheimer's. People had also been diagnosed with Parkinson's. Staff told us they had received basic training in dementia awareness, parkinson's and challenging behaviour but felt they needed more comprehensive training, particularly around communication and managing behaviours. A member of staff commented "it's hard to understand what people mean and their behaviour and how to respond in the best way". All of the staff told us they would welcome more training in how to support people with behaviours which may challenge, how to de-escalate situations and breakaway techniques, particularly as some people tended to grab the arms of staff whilst being supported.

Whilst we were located on the ground floor we overheard a conversation between one person and two members of care staff. The staff were unable to understand what the person wanted which led to the person becoming increasingly vocal and distressed. We discussed this with the registered manager and stated our concerns. We did not find that all staff had the necessary level of understanding of people with dementia or mental health needs. This meant staff were not able to offer a consistent approach to individualised care, particularly for people who may react aggressively if they felt threatened or cannot understand what is going on around them.

This was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care from nursing and care staff who were supported to maintain their qualifications and develop their professional's skills. The training records for all staff roles evidenced they had received training in the mandatory topics such as, safeguarding, fire safety, infection control and manual handling. Staff said they had completed qualifications in health and social care and most had previous experience of working in a care setting. Staff undertook additional training which was relevant to their role, such as pressure ulceration prevention, epilepsy awareness and nutrition training.

Staff told us they had either received supervision or were waiting for a date. The registered manager confirmed they had recently put together an up to date schedule of supervision and appraisals since coming into post in October 2015. Nursing staff had weekly clinical meetings and daily handovers where issues were discussed and information exchanged. Staff confirmed they received information about training courses and reminders when refresher courses were due. Staff had either received an appraisal to consider their individual progress and development or were waiting for their appraisal date.

People told us they enjoyed the food. One person told us "this is a very nice home, the food is great". The quality of the food was good and people could request an alternative if they did not wish to have the menu which was on offer.Throughout our visit, people were offered drinks and snacks. The menu on the first day of our inspection was turkey and ham pie or poached fish with broccoli and mix vegetables and a choice of mash/croquette/chips, and a desert of semolina or fruit cocktail with the addition of ice cream which was not on the menu.

We saw a flipchart pictorial menu but were told by the kitchen staff that this was not used. Some people would have benefitted from selecting their choice from a pictorial menu which would enable them to visualise their choice. In addition, as meals were chosen the night before, this may impact on the independence of a person with dementia who may not be able to remember what they had ordered the day before.

We observed a care worker assisting one person to eat, they were kind and considerate, the person was not rushed, and allowed them time to chew and swallow before offering more food. As the member of staff assisted the person they asked them "are you ready for some more" and waited until they were ready, however, they did not give a description of what food was on the spoon, thereby not giving the person the choice to accept it.

We spoke with the deputy kitchen manager who explained "menu choice can be changed with other meals from the menu provided which had been organised by the BUPA head office." At this time they supported people with specialised diets such as gluten-free and a fish allergy. They received information from the nursing staff around fortified diets and provided this through using high calorific ingredients, although they were not aware of the calorific values of the meals which were fortified. A care worker was able to explain to us why people may require their drinks to be thickened and they used the care plan and instructions from the nurses in relation to this.

Requires improvement

Is the service effective?

People were supported to access health care services such as chiropody, optical and dental services who offered visits to the home to see people. Referrals were made to various consultants relating to people's health needs.

The home had recently undergone a refurbishment. The width of the corridors accommodated wheelchair users. There was a lift between the ground and first floors and hand rails were provided throughout the communal areas of the home, including the bathrooms and toilets.

Good

Is the service caring?

Our findings

People appeared comfortable and relaxed in the presence of staff and staff spoke with people in a respectful and caring manner. We observed staff knocking on doors before entering the room and personal care was carried out in the privacy of the person's room with the door closed.

Staff supported people to make choices, for example in what drink they wanted or what they wanted to do, such as joining people in the lounge. Some members of staff were particularly good at engaging with people and promoting two way conversations.

Most people spoke highly of the care they received. Comments included "I am mostly well looked after, but it does depend on the carer. There are many more men carers now, and this can take some getting used to", "the staff all treat me very nicely" and "I am a great grandma now and they [the family] bring my great-granddaughter in sometimes which is lovely, I am very happy here. If I need anything I mentioned things to the staff who help me each time, they really are very helpful." Another person said "the carers are very good and I am well looked after," while the relative said "she used to be very down but since coming here is much better."

The staff were enthusiastic and dedicated to providing people with a good quality of care. One member of staff told us "I think the care we give here is phenomenal". Staff told us "I enjoy coming to work" and "I love doing this job".

Staff told us that they would definitely recommend the home to any of their relatives if the need arose. Staff demonstrated that they knew people's preferences for care, including likes and dislikes for food. They were also able to tell us how they knew if people were in pain and during our inspection we saw nursing and care staff approached people to make sure they were pain free and comfortable.

The management team felt they provided person centred care to people who use the service. They gave an example of a person who used the service who would not have another opportunity to spend a birthday, Easter or Christmas with each other. Staff showed dedication over a period of six weeks, where they planned these events for the person and their husband to spend together. They brought her birthday forward to receive a card from the Queen.

Information was available to people regarding advocacy services. [Advocacy is a process of supporting and enabling people to express their views and concerns and access information and services through an impartial service which is independent of family or the service].

Within people's care records was information relating to their end of life wishes.

Requires improvement

Is the service responsive?

Our findings

During our observations of the care people received we found care was good at the point of delivery, however, the care records did not reflect the care people received.

We looked at fourteen care records. We found care plans were not person centred as they were not sufficiently tailored to individual preferences and abilities. They lacked information about how the person wished their care to be delivered. In particular personal preferences for care routines such as washing and dressing including the type of clothing people liked to wear. There was little information about people's likes and dislikes around food including cultural preferences.

The sections in the care plans about the person's background and family history lacked detail, including their previous work roles, significant achievements or events and hobbies and interests the person had. The section on communication did not give enough detail on how the person communicated including non-verbal means and how the home would aid the person's communication. Within the communication section staff were asked to tick a box if the communication of the person was 'normal' without having a definition of what 'normal' meant. There were mental capacity assessments where people were deemed to have capacity to consent to their care planning, yet two out of three care plans were not signed by people or ticked to say the person had been involved.

There was a lack of detail in the care records to ensure that all staff delivered care to the person in a consistent way. Non descriptive instructions were given such as, oral care 'give mouth care at every tilt', 'staff to reassure and give support when needed' and 'assist to maintain personal hygiene'.

A standard statement was used to describe people's emotional wellbeing without a description of how this presented itself for the individual person, such as 'X gets anxious and depressed at times'. When people answered the questions on the depression questionnaire and their depression score was high, they were not asked why they felt their life was empty or they felt helpless.

There was not enough information on how people's mood, depression or behaviours presented themselves, the triggers to be aware of and how all staff should respond in order to fully and safely support the person. A member of staff told us that one person could be 'having a nice conversation one minute and the next unpredictable and the next they are aggressive, they are not rational'. This statement demonstrates a lack of understanding of mental health and emotional wellbeing.

Staff told us overtime they had 'gotten to know the way that people preferred their care' to be delivered, however this information was not captured within the care plans. A member of staff told us "one member of staff knows exactly how to support X when they become challenging but others will avoid X". We asked if one member of staff was particularly good at working with and calming X, why a description of how they supported X was not written in the care plan, they stated they did not know why.

We found the recording of peoples weight, highlighted anomalies which had not been picked up as part of the person's weight management. This could have an impact on the person not receiving appropriate and timely follow up of their care. Examples were one person who had gained 3.2kg in weight over five days, another person had gained 4.6kg in three weeks and one person had lost 25% of their body weight in just under a year.

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

There was one activities coordinator who worked four days a week and care staff also provided some activities. There was no record of the attendees to these activities or of those who had declined, we therefore unable to ascertain how many people participated. The outside entertainer who visited on the day we were there had been pre-booked before our inspection. We were told there was one main activity booked each week and this was usually held in the communal lounge on the ground floor. Other activities took place such as word games, puzzles and listening to music. Within the home there was a hairdressers and one person told us they enjoyed having a 'hairdo'. Ministers of different faiths visited the home to offer spiritual support and some people attended church with their families.

Volunteers visited people in their rooms once a week alternating between the floors. They recorded those they had visited on a resident list sheet but there were many names with 'sleeping' written against them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the

Requires improvement

Is the service responsive?

experience of people who could not talk with us. The observation took place after lunch. We found the people we observed were asleep and did not have interaction from care staff. The layout of the building could lead to social isolation as some of the bedrooms were far down the corridor. For people who were nursed in bed there were not many opportunities for one to one social stimulation available.

The complaints procedure was displayed within the foyer of the home and people told us they were confident their concerns would be looked at. One person said “I’ve not really needed to, but I would be happy to raise a concern or make a complaint as I know all the staff on the unit by name and get on well with them.”

Requires improvement

Is the service well-led?

Our findings

We looked at the Do Not Resuscitate forms (DNAR) held in people's care records. The forms had been completed and signed by a health professional, yet for the newer style forms, the back section which considered the capacity of the person to make that decision had not been completed. On the older type forms there was no evidence of the mental capacity assessment process having taken place. On some forms there was conflicting information with both the communication boxes being ticked without explanation and there was a lack of recording regarding what steps had been taken to involve the person in the decision being made. Although the forms had not been completed by the provider, it is the responsibility of the provider to ensure the process of determining capacity for decision making is followed as legally required. There were no clinical audits of the 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms to ensure they had been completed in line with current legislation and the decisions made were appropriate and lawful.

The provider had failed to ensure that people's confidential information was maintained securely. The ground and first floor medicines rooms were left open during the two days of our inspection and the room was accessible to people without authorisation. In the ground floor medicine room, a filing drawer was left open which contained people's confidential medical records and people's medicine prescriptions had not been locked away. In the first floor medicine room, people's confidential medical records were accessible as the filing cabinet was not locked, confidential records were left out on the desk and handover information containing people's personal care details were stored on an open shelf in the room.

Throughout our inspection, relatives and people told us they felt there were staff shortages, particularly at weekends. We discussed this with the registered manager who supplied us with the call bell response times for a random selection of a Monday and a Friday in October 2015 and two Sundays in November 2015. The provider requires that call bells were to be answered within seven minutes. On weekdays, seven percent of calls were not answered within the seven minutes required. On the weekends this ratio was three percent. The length of time some people had to wait was variable, with waiting times anywhere from nine to 32 minutes. This meant people had to wait for the attention they needed from the staff.

The registered manager told us they discussed the call bell response times with staff with a reminder that call bells were to be answered within the timescale given. We found the information gathered through the call bell response times was not being used to fully investigate and identify trends in order to mitigate potential risks to people. We discussed this with the registered manager.

The registered manager explained that the provider had recently introduced a new care plan template. We saw that staff had completed the new care plans which included sections on nutritional screening; falls risk assessment, daily notes and geriatric depression scale as an example. The new form was comprehensive in the information it gathered, however, we found the template used to record the mental capacity assessment and best interest decisions in relation to the care planning process, lacked space for staff to record sufficient evidence of the processes followed.

Stage two of the form states that all practical and appropriate support to help the person make the decision must be attempted before carrying out the test for capacity. On all of the mental capacity assessments which had been completed there was insufficient evidence to confirm that the provider had carried out stage two as legally required.

The registered manager ensured that audits were carried out; however some of the audits did not identify the issues we found. The care plan audit did not identify that people's confidential information was not stored securely. . The medicine audit did not identify the issues with non authorised staff accessing the medicine room or that the medicine rooms were not locked as required by the provider.

Within the provider policy of medication, access and storage we could find no information which related to the storage of prescribed fortified drinks which people kept in their room, to ensure they were safely stored without risk to the individual.

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

Requires improvement

Is the service well-led?

There was a registered manager in post . There was an open and transparent culture within the home and the service had clear values about the way care should be provided and the service people should receive. Staff had clearly defined roles and understood their responsibilities in ensuring the service met people's needs. Staff told us they felt valued by the management team, in particular the registered manager who they felt was making positive changes to the home. All staff told us she was approachable and would listen at any time.

During our inspection people told us they had been cold during the night as the heating had not been working properly in some of the bedrooms. The registered manager had submitted a notification to the CQC regarding the loss of heating to several of the bedrooms. Additional heaters had been placed in people's room and the maintenance person told us the replacement boiler part would be fitted within the next two days.

The registered manager and area manager told us the home had been successful in being able to offer intermediate care beds to free up acute hospital beds. They were working closely with Wiltshire Council and were able to access their training, especially around rehabilitation goals. They have identified an Intermediate Care lead nurse, who completes admission assessments to ensure appropriate admissions.

A further success was the completion of the refurbishment of the whole Home. People who use the service were included and given a choice of colour schemes for the decoration of their rooms. Family and friends were invited to a re-launch day where the management team received positive feedback about the refurbishment.

The service was fully staffed and did not have to use agency staff. The registered manager felt they worked towards empowering their staff and had introduced the team leader role. Staff were shown appreciation for their work by acknowledging long service for staff who have been employed at the home for more than 15 years. They also had other activities to motivate staff, for example pay day breakfast, where staff have the opportunity to eat with people who use the service.

The registered manager was newly appointed and told us they needed a few more months to reinforce changes they wanted to make, one of which was the management of Deprivation of Liberty Safeguards and implementing the principles of the Mental Capacity Act (2005). Staff champions were being identified to lead core subjects such as Infection control Dignity, End of Life care and Wound care. They encouraged improvement by observing staff practice and encouraging senior staff to observe and feedback as needed. The area manager visited unannounced with the service manager at times to observe either day or night practice. The management team told us they were committed to improve staff retention and to develop further training for staff.

The management team worked towards building relationships with the local community. They had a good relationship with the local Infant school, who visited especially at Christmas time. They also had volunteers from the community to visit the Home. They were supportive towards their neighbours, for example provided help to maintain the neighbour's garden and supported the person when they had a fall in the garden. They also wrote to their neighbours to inform them of the refurbishment and to keep disruption to neighbours to a minimum.

The provider had a Duty of Candour Policy and there was a complaints procedure was in place. The registered manager was confident that complaints were dealt with in an effective way.

The registered manager kept up to date with new legislation, policies and procedures by attending a monthly manager's meeting. Information was also cascaded down from senior management. The registered manager ensured that weekly, monthly and quarterly audits were completed. Quality assurance was also completed by the organisation centrally and a quality assurance team with a QA manager was available.

Clinical training was available for manager's to complete and they adhered to the National Institute for Clinical Excellence (NICE) guidelines. The registered manager was signed up to the Wiltshire Care Partnership and worked towards building relationships with other manager's by attending meetings with other care homes. The registered manager worked proactively to encourage professional development by arranging regular speakers on subjects such as DoLS, CQC, Resuscitation and Treatment Escalation plans.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people as there was a lack of proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not follow the requirements of the Mental Capacity Act 2005 when people lacked the capacity to give consent to their care. Necessary applications for the authorisation lawfully to deprive people of their liberty had not always been made. Best interest decisions was not being recorded as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not have the required skills to be able to appropriately support people with dementia and behaviours which may challenge. Staff did not fully understand the processes and their responsibilities in relation to the Mental Capacity Act 2005 and best interest decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of accurate and complete person centred recording in place in respect of people who used the service. Audits in place did not fully identify shortfalls in the service provision.