Jurvicka Limited

Sandhurst Residential Home

Inspection report

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16 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 22 people lived at the home, some of whom were staying temporarily. The bedrooms are on all three floors, which can be accessed by stair lifts.

This unannounced comprehensive inspection took place on 29 September, 4 October, 10 October and 16 October 2017. It was carried out in response to reports from community nurses relating to how people's pressure care was managed. We found improvements were needed to reduce the risk of pressure damage for people living at the home.

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 first comprehensive inspection in connection with the new legal identity. However, the registered manager and the provider have stayed the same.

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 was not a consistent approach to making applications to the local authority in relation to some people who lived at the service. People were not routinely involved in their assessments, care plans or reviews so their consent was not gained. Best interest decisions were not recorded and documentation linked to lasting power of attorney was not requested. These practices meant people's legal rights were not protected.

Some risks to people's health were not well managed, for example monitoring people's weight. Lessons had not been learnt from an incident relating to poor pressure care. Staff had to be prompted to check the setting of a person's pressure mattress. It was incorrectly set on two separate occasions and put the person at increased risk of pressure damage. They had also been at risk of entrapment in their bedrails, which staff

had not noticed. We ensured action was taken during the inspection to reduce these risks to the person's health and safety.

Recruitment practice did not ensure all the necessary information was in place before staff started working at the home. Staff training did not routinely include practical training, although the registered manager began to book this type of training during the inspection. This was in recognition that staff benefited from hands on training for some areas of care, such as using moving and handling equipment. We saw examples of kind care, with staff showing affection and compassion towards people. However, there were also practices which undermined 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. The management and storage of medicines required improvement. People were supported with their meals, where needed, but people's weight and fluid intake was not monitored in a robust way.

Safety checks were carried out but the systems in place were not thorough and potentially left people at risk of harm. Some areas of the home were potentially unsafe to people living with dementia. Staff practice showed a lack of understanding of infection control. Some items of furniture were damaged or stained. There were areas of the home which were poorly maintained.

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 in staff skills and knowledge in supporting people living with dementia and people with complex health and emotional needs. People were not always provided with meaningful interactions which meant they were at risk of social isolation. There was no system to ensure activities happened regularly and met people's individual interests.

The service was not well led. During our inspection, we found a number of areas that needed to improve to maintain the safety and well-being of people that had not been identified by the registered manager or the providers. We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service.
This will lead to cancelling their registration or to varying the terms of their registration.

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.

During the inspection, we shared our concerns with the local authority safeguarding team, commissioners, deprivation of liberties team, fire service, community nursing team and the clinical commissioning group so they were aware of the potential risks to people's safety and well-being at the home. We made an individual safeguarding alert for one person who has since moved from the home. The local authority safeguarding team are organising a strategy meeting to discuss the whole service.

Since the inspection, we have been in further contact with the registered manager and the provider. They have assured us they wish to improve the service and have begun organising new training for staff. The registered manager has sent us a list of the action they have taken so far. For example, fire equipment being serviced, new furniture and improved practice in medicine management. They have stated they will work alongside the local authority quality assurance and improvement team to make further improvements.

CQC have taken enforcement action by imposing a condition on the provider's registration. This requires the provider to provide CQC with a monthly report outlining actions and progress in making the required improvements. We will inspect this service again within the next 12 months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The environment was not always safe.

Improvements were needed to reduce people's health risks.

Staff knew to report suspected abuse.

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

The recruitment process did not ensure people were cared for by suitable staff.

Infection control practice did not keep people safe from the risk of cross infection.

There was not an effective system in place to assess staffing levels so the registered manager could not demonstrate staffing levels met people's care and social needs. However, people were positive about the availability of staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff training did not provide 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 not consistently protected as deprivation of liberty
safeguard applications were not always made in a timely manner. People or their representatives were not 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. However,

consideration had not been given to make mealtimes a pleasurable experience. Recording was not consistent to help monitor the risks to people's health, including weight loss.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

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

Some practices undermined people's privacy and dignity.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's social and emotional needs were not always taken into consideration. Activities to motivate people and promote a positive well-being were not routine and there was no system to ensure they happened regularly.

The complaint process was not accessible to everyone visiting the home. Complaints were investigated in line with the home's process.

Is the service well-led?

Inadequate

The service was not well led.

There were ineffective systems in place to monitor the quality of care
provided and keep people safe.

A lack of environmental safety checks potentially put people's safety at risk.

Systems in place did not guide staff to ensure good practice was consistently provided.

The provider had not conducted thorough audits of the service to ensure people were receiving safe and good quality care.

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.

This unannounced comprehensive inspection took place on 29 September and 4 October 2017. The inspection team comprised of one inspector on first day and two inspectors on the second. We returned on a third day which was announced to ensure the registered manager was available. A medicines inspector also visited the home on 16 October 2017.

A Provider Information Return (PIR) was completed. 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 the community nurse team relating to specific safeguarding concerns linked to pressure care.

We met most of the people using the service and spoke with them about their experience of living at the home, and spoke with six visitors and relatives. We looked at four people's care including their care plans. A number of 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 eight 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. We sought feedback from commissioners, and health and social care professionals who regularly visited the home. We were received feedback from the community nurse team.

Inadequate

Our findings

We judged people's safety was at risk. This was because risks to people's physical safety and risks to their health were poorly managed.

The environment of the home potentially put people's safety at risk. Building work to replace a bedroom ceiling was taking place. On the first day of inspection, the bedroom door had been left open. People living with dementia had access to the tools that had been left in the room. The registered manager said the room should have been locked and locked it. However, on two occasions on the second day the same bedroom door was unlocked; there were potential trip hazards as ceiling tiles and paint tins had been left on the floor, which we highlighted to the registered manager so they could address the risk.

On the first day of inspection, large bottles of cleaning fluids were left unattended in the doorway of a bedroom, these were accessible to people living with dementia who may not recognise them as being dangerous to their health. The registered manager said they would remind staff to supervise cleaning equipment.

Environmental risk assessments were not in place to provide guidance and direction for staff about how to support service users and ensure that care and treatment was provided in a safe way. A risk assessment had been completed in case the stair lifts were not working. However, it did not provide 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. However, they had not identified that two doors on the top floor were not operating correctly. The registered manager was unable to identify how long this had been the case and why one had a bolt on it. They assured us this would be addressed as a priority and we saw the issue had been addressed by the second day of the inspection. Following feedback from us, they planned to make changes to the fire alarm test to visually check equipment was working effectively.

Fire records showed checks were made on a regular basis, for example, emergency lighting. However, there was not a list with people's names and room numbers on it to be used in the event of an emergency. There was no log of where the fire extinguishers were kept making an audit of equipment difficult for staff members other than the registered manager who knew this information. The registered manager said they had not completed a personal evacuation plan for anyone living at the home, which they said they would

address as a priority.

During the inspection, we met a person who was cared for in bed. The registered manager said bedrails were used to reduce the risk of them falling out of bed, which had been agreed with health professionals. However, we highlighted to the registered manager that the person was at risk of entrapment due to the way equipment had been set up. The registered manager took immediate action to make the person safe. Risk assessments were not effective. For example, the risk assessment for the use of bed rails did not provide a checklist for staff to ensure the equipment was safe and correctly used.

By the second day of inspection, the registered manager told us they had changed the bed, which had a different type of bed rail. We checked the setting of the pressure mattress on the new bed; it had significantly changed from day one of our inspection. The registered manager said they did not know how this had happened and returned the setting to the original level, which we had seen on the first day of our inspection. The setting level for specialist pressure mattresses is based on people's weight. There was no weight record for this person despite them living at the home for four weeks therefore the setting may not have been accurate. Before we left the home, the registered manager asked staff to weigh the person so they could ensure the pressure mattress was appropriate. When we returned on day three, we saw the setting on the mattress had changed for a third time. The registered manager said this was because they now had taken the weight of the person and the previous settings had been incorrect. Pressure mattresses which are not set correctly can place people at further potential risk of pressure damage to their vulnerable skin areas.

The person had been assessed by a health professional as being at 'high risk of pressure damage' and needing to be re-positioned every two hours. A risk assessment had not been completed to show how this risk would be managed. There were turn charts in the person's room stating the person should be turned every '2-3 hours'; each sheet stated 'This is very important that this is done'. There was no record these charts had been checked on a regular basis to ensure this action by staff had occurred. We reviewed a period of four days. On one occasion, records indicated the person was not turned for three hours and fifty minutes, which was over the advised timescale. On another occasion, it was recorded the person had 'refused' to be turned by staff. There was no log that staff had returned to explain the risk to the person who was judged to have capacity to be involved in decision making. Therefore according to records, they had not been moved for over seven hours, potentially putting them at an increased risk of pressure damage to their skin.

In July 2017, the community nurse team had made a safeguarding alert for another person living at the home whose pressure sore had deteriorated causing a larger wound. Following the second day of our inspection, we made a safeguarding alert to the local safeguarding team. This was because we were concerned that a person who had been assessed as being at high risk of developing pressure sores was at risk because bedrails and pressure relieving equipment were not being used safely or effectively. Despite staff recently receiving pressure care training as a result of the safeguarding alert in July 2017, we judged risks to the person's health were poorly managed.

There were no risk assessments in place in respect of peoples' individual needs. For example, people did not have risk assessments in place in respect of their nutritional risks. A person was cared for in bed and was being supported by staff to eat and drink. Health professionals had assessed staff were needed to ensure the person had 'adequate nutrition and hydration.' We checked the person's fluid records, which were recorded in a variable manner, such' half beaker', 'half juice' or '200mls'. This meant the intake of fluid could not be totalled on a daily basis. There was no goal for staff to aim for each day which meant the records were not meaningful.

People were at risk because there was not an effective system to show how weights were monitored and reviewed. Monthly reviews did not identify changes to people's health, such as weight loss. We could not find weights for everyone living at the home. Staff reviewed the folder and found some people's records had been misfiled. This meant one person had not been weighed for three months but this had not been identified. We highlighted this omission to staff but this was still not rectified when we returned a week later. One of the reasons given for the person's admission to Sandhurst was because they had not eating well at home so an identified risk to their health was not being effectively managed. The registered manager said they thought staff had weighed the person following our feedback; they said they would ensure this was addressed.

There were areas of concern which posed a risk to people due to a lack of effective infection control and prevention procedures. The service did not refer to the guidance from the Department of Health: Infection Prevention and Control in Care Homes. The laundry room was sited outside of the main building, adjacent to an outside seating area. It was very small and not well laid out. There was no clear separation for clean and dirty laundry which increased the risk of cross infection. The laundry room was cluttered and very dusty, particularly behind the washing machines and tumble driers; other areas were not easy to keep clean such as the walls and floor. Staff said the floor was washed every day but no other regular cleaning of the laundry room took place. There was a hand washing sink in the laundry room but this was not accessible and staff confirmed it was not used either to sluice washing or to wash hands.

Care staff placed dirty laundry in a linen bag. They then placed it in the clean linen cupboard under the stairs at the home. This meant dirty laundry was stored next to clean bedding which increased the risk of cross infection. Disposable plastic bags were available to store and indicate soiled or infected linen but these were used inappropriately and therefore did not eliminate the risk of cross infection. Heavily soiled linen was soaked in open waste bins or buckets; we saw there were four of these in use in the garden. People living at the home had access to this area.

Some staff wore personal protective equipment (PPE), such as plastic aprons and gloves. However, staff practice indicated they did not understand its purpose. For example, a staff member working came out of the kitchen, walked around the home and returned to the kitchen with the same apron and gloves on.

The medicines were stored in a lockable trolley and also in a medicines room. The trolley was kept in the hallway adjacent to a radiator but there was no additional monitoring of the temperature of the medicines within the trolley if the trolley came in contact with the radiator. This could mean the medicines were not always stored in accordance with the manufacturer's instructions. The medicines room was secured by a lock. But the type of key could be bought freely in any hardware store. Some of the cupboards used for the storage of medicines within the room did not meet the correct regulatory standard. This meant that the medicines were not stored securely. This was raised with the manager at the time of inspection; they agreed that this would be actioned immediately.

The service was using an electronic medicines administration recording system. Staff said this was a new system, they had identified they needed further training about how to audit the completion of the records. When people were prescribed creams the record did not always reflect who had applied the cream. We saw there were not always clear directions about where or when the cream was to be applied either on the label or within the person's care plan.

People were prescribed medicines to be administered "when required". There were no clear directions for their use either on the labels or in the person's care plan. A member of staff said they would know when to give the medicine but also said other staff may give the medicine at different times. The outcome of using

these medicines was not recorded either on the medicines administration record or within the daily care record. This means people could not be assured that they will receive consistent and effective care.

There were a number of sterile products that had passed their expiry date. A member of staff said there was no record made to show that these were checked and monitored. A medicines fridge was used but there was no monitoring of the temperature range of the fridge. This means medicines and dressings might not be fit for use. The manager said they would arrange for the expiry dates to be checked and also change the system for monitoring the fridge it was not possible to show the service had made safe arrangements to manage medicines and monitor if these were being followed. We discussed this with the manager during the inspection.

All these areas of concern were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being administered to people by a member of staff. This was seen to be carried out safely in a caring manner. A health professional had not seen medicines being administered by care home staff so could not comment on their practice. They said when they visited to administer medicine, such as insulin, it was stored securely.

On the third day of inspection, the registered manager had supplied a linen trolley with three compartments for care staff to put dirty linen. This was stored in the downstairs corridor of the home. Staff kept a record of which rooms were deep cleaned but these were not carried out routinely instead staff said "as and when needed". Two housekeepers were undertaking a mix of cleaning duties and laundry duties to cover the shortfall in laundry hours. There was no audit system in place to check the cleanliness of the service. Most rooms smelt pleasant but a visitor told us there had always been an underlying unpleasant odour in their relative's room before they moved into to it but the source had never been discovered. They said air fresheners were used to mask the smell.

Recruitment practices at the home had the potential to put people at risk as the registered manager did not ensure new staff were suitable to work with vulnerable people. One recruitment file contained all the necessary information required to employ a person safely. However, two did not. They contained poorly completed application forms. For example, they did not include the names of previous employers and the dates people were employed. Suitable references were not always applied for and received. For example, one person's reference had no name of the person completing it or where it had come from. Another recruitment file held three references but only one of these was the name of the referee on the application form. It was not clear who or where the other two had come from as they were not signed or recognisable. Gaps in employment history were not routinely discussed or recorded. Any gaps were not highlighted as the application forms did not show these. The registered manager said they had not seen a new staff member's health qualification, although they had requested it. The staff member told us their college qualification was not related to care. These deficits in staff recruitment were discussed with the manager who recognised their practice was unsafe.

This is a breach of Regulation 19 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, some records were kept of their interview although these were minimal and did not explore their skills, knowledge and attitudes. At the end of each interview the registered manager took the future

employee to meet people in their home and later asked their opinion. For example, one record stated "I took (prospective employee) around the home and introduced her to some service users … seemed to interact well towards them all."

A staffing tool was not used by the registered manager to determine staffing levels at the home. Care assessment tools also did not influence staffing levels so the registered manager was unable to demonstrate how they judged the current staffing levels met people's care and social needs. The registered manager was unable to show through their records how they had judged they had the correct staffing levels to meet the needs of new people moving to the home. For example, people with complex care needs or requiring palliative care.

The rotas showed there were generally five care staff on in the morning, which included a senior. This reduced to three or four care staff, including a senior in the afternoon after 2pm. This reduced to three care staff after 7.30pm. However, at least once a week a senior staff member completed office work in the afternoon which took them off the floor. A staff member said in the evenings staff could be "rushed off their feet", particularly when care staff had to prepare the tea time meal.

The registered manager and staff told us four people needed two staff members to assist them to move safely. Their rooms were on different floors. Two people were mainly cared for in bed and needed support to move at night. There were two care staff on duty at night. The rotas were not clear as shifts were not recorded using the 24 hours clock and the registered manager did not include their own hours, although they said they would assist staff if needed. The rotas provided to CQC by the registered manager did not include housekeeping, laundry or catering staff, whom we met during the inspection.

We recommend staffing levels are reviewed using a recognised staffing assessment tool when people are admitted to the home again to ensure people's social and care needs are met.

People told us they felt safe. Several people told us they had uninvited people living with dementia come into their rooms; they said they did not mind and would call staff if they needed help with asking people to leave. However, a staff member said one of these people became agitated and shouted at one particular person if they mistakenly entered their room. We fed this back to the registered manager and have asked for further information as to how this risk is being managed to help keep people safe.

People in their rooms had accessible calls bells and knew their purpose, although some said they chose not use them and waited for staff to call in. 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.

A staff member understood their responsibilities to report abusive practice. However, they had not completed training in safeguarding despite working at the home for 15 months. This was addressed during the inspection. Other staff knew their responsibility to report abusive practice either internally or externally; they said there were no current concerns.

Requires Improvement

Our findings

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The 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.

After the second day of the inspection, we contacted the local Deprivation of Liberties assessment team. They had not received applications for all of the people living at the home who met the DoLS criteria. For example, for people who had equipment that could infringe on their freedom or restrict their movement such as bed rails or sensor mats to alert staff to a person moving around their room. The registered manager had advised that an urgent application had been made for a person on a respite stay, which a letter from the DoLs team confirmed. This was made four days after their move to the home despite a risk assessment stating that person felt they should live in their own home. During the inspection, other applications were made retrospectively for people living at the home.

Some staff had undertaken training on the MCA and DoLS but not all staff were clear on what this meant. Relatives had not been asked to show legal documentation to confirm they were authorised to make certain decisions on the person's behalf. This indicated staff did not recognise people could not provide consent on the person's behalf, unless legally authorised to do so. Where people lacked capacity, there was no documentary evidence that people's capacity to make particular decisions had been assessed.

No records of best interest decisions had been made. For example, one person living with dementia had a sensor mat in their room, their relative said they had been told about the mat but there was no record of this discussion. The registered manager said staff used this to monitor the person's safety and wellbeing. Other people had similar needs but did not have this equipment in place. However, there was no documentary evidence that a mental capacity assessment had been undertaken to assess whether the person had capacity to consent to this. Also there was no record of a best interest decision about the use of this equipment, which was intrusive.

Care records did not show how people had been consulted about their care. For example, care plans were

not signed by people living at the home who had the capacity to be involved in discussions. Some people living at the home had a diagnosis of dementia, their relatives had not been asked to review the care plan and sign on their behalf even when relatives had the legal power to do so. Since moving to the home, some people had changed bedrooms; records had not been kept as to how these decisions had been made and who had been consulted.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, one person said it had been their choice to move room and two people's relatives said they had been consulted.

Staff training did not provide staff with adequate knowledge or the practical skills to provide care based on current practice. A staff member who was new to working in care had not been inducted using the Care Certificate. This national qualification gives staff a strong foundation to understand the principles and values of care work. The staff member had not worked in care before; they were registered to start this training during the inspection. The registered manager said this usually happened once a person had completed their three month trial. Staff gave variable feedback on how their training needs were met. One staff member felt they did not need any further training. In contrast, another staff member identified they did not really know how to look after people living with dementia but said they felt well trained for their job.

A number of people were living with dementia but not all staff had completed training in dementia awareness and other staff members' training had not been updated. Discussions with staff confirmed this was an area for further development as they commented more people were moving in with a diagnosis of dementia; one said there were "different types, some have vascular, others are aggressive".

In discussion with the registered manager, they recognised people's care needs were becoming more complex and staff needed training that gave them increased knowledge and skills. The registered manager said most training had been completed on-line. We discussed the changing needs of the people living at the home, including people who needed equipment to move them, and the registered manager decided to instigate practical moving and handling training for staff. By the second day of our inspection, they had made enquiries and planned for this type of training to be delivered to staff by a health professional. Following a safeguarding alert by a health professional in 2017, staff had recently completed training in pressure care. However, practice during the inspection highlighted that further work was needed for staff to understand the risks and how to document decisions.

Consideration had not been given to increase the independence of people living with dementia. Only one of the bedroom doors had another identifying feature apart from a number. One room being used for a person living with dementia and on an emergency respite had no number. The room was at the top of the home; there was no signage to help the person how to find their room. On the first day of inspection, they were assisted by staff to find the communal areas but looked restless and unsure of where to sit or what to do.

We met another person who told us they were looking for their bedroom; we met them on the top floor of the house. Their room was on the floor below. They said to us "I walk around and wonder where I am". We asked a member of staff to help the person to find their room; on entering their bedroom the person said "I'm back home now". Their bedroom had a sign on the door with their name on it but there no other signage to guide them to this part of the building.

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. A number of people told us they were happy with their rooms, which were personalised. One had damaged wallpaper in one corner and stained ceiling tiles. Another bedroom had a chair with stuffing coming out of the arm. A third bedroom had a broken sink unit. Maintenance records or quality assurance checks had not identified any of these issues. There was a courtyard which people living at the home could use, which the registered manager said was secure. There was a step into the courtyard from the dining room. The registered manager said there was a portable ramp but this was not in permanent use, which could potentially impact on people's freedom to use the courtyard. There were plants in flower pots but none had been raised to make them more accessible to people living at the home.

Whilst some furniture was clean and in a good state of repair, there were other items which were not. For example, two divan beds had brown stains on the side of them and a chair had a brown stain on the seat cushion. These had not been identified by staff or the provider as an issue to be addressed. These were discussed with the registered manager who immediately purchased two replacement beds and said the stained chair would be changed. One visitor said a social care professional had advised them to look beyond the decoration when choosing a place for their relative to live.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living at the home positively commented on the appearance of their rooms. Some visitors were also complimentary about their relative's bedroom, for example the size.

Some people were able to tell us that their health needs were monitored by staff and they had access to health 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. The staff communication book and care records showed health changes were acted upon by staff, for example recognising a person was developing a urine infection and ensuring they gained a urine sample and involved the GP. Staff commented that the person's health, mobility and well-being was now improving as medicines were prescribed to address the issue. Staff attended a handover to update them on people's changing needs. Staff were able to describe how risks to people's health were managed. For example, regularly assisting a person to stand to prevent pressure damage.

Health professionals visited the home daily to deliver community-nursing support for up to four people. In 2017, they have made safeguarding alerts in relation to two people's care at the home. However, they were confident staff recognised changes in people's health and would request support from health professionals in a timely way and follow advice that was given. Their view was the systems to measure and record risk to people's health were not always effective.

People praised the quality of the food, which was home made. Visitors also commented on the standard of food and the homemade cakes. People were positive about their meals as they ate them, commenting on flavours and describing the food as "outstanding" and "lovely". 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 hot drink prepared.

However, consideration had not been given to make mealtimes a pleasurable experience. During the day,

tables in the dining room were covered with a tablecloth but these were removed when people ate their meals. Table tops were worn; there were no place mats or serviettes. On the first day of inspection, a salt and pepper pot was shared around the tables and on the second day a person had to request condiments. Jugs were not available so people could not help themselves to a drink. For example, one person quickly finished a drink from a plastic beaker and had to attract staff attention to have it refilled. On the third day of inspection, people did not have a drink with their meal. The style of the dining room meant that staff were continually passing through it to collect meals for other people in other parts of the home. There was not enough space for everyone living at the home to eat in the dining room, although a number of people said they preferred to eat in their room.

Requires Improvement

Our findings

Some aspects of staff practice did not promote a culture that respected people's privacy and dignity. Staff did not always remember to knock on bedroom doors before entering. People confirmed this but said this did not impact on their privacy. One person spent their day sitting in the dining room by the kitchen doorway. They told us this was their choice. Staff usually greeted them as they passed by but this meant communication was on a basic level and not for any length of time. Staff shared information about other people living at the home when they gathered in the kitchen which was within this person's hearing. This meant confidentiality was not always maintained. Care records were kept in an unlocked cabinet in a communal area.

Some staff practices undermined people's dignity. For example, a staff member assisted one person to eat but wore gloves while they were doing this and another staff member in the lounge wore gloves to assist a person to stand. Some staff were more skilled than others at involving people in day to day choices and checking with them before they carried out a task. For example, one staff member checked if they could assist with cutting up food to help a person eat independently. In contrast on another day, another staff member just cut up the person's food without checking if this was acceptable to them. Some staff took time to explain what the meal was and others did not. A health professional judged that the staff group had a mixed range of skills with some staff having a "wonderful" approach and "others less so". Another health professional commented on the caring and affectionate nature of staff.

The registered manager had agreed to the admission of person with end of life care needs but the majority of staff had not received training to provide this type of care and staff who had completed a course had not updated their knowledge. Two people living at the home had been assessed as needing end of life care by visiting health professionals. However, there was no end of life plan in place. Their wishes about how they wanted to spend this part of their life had not been explored, and put in place, to ensure these wishes were met by staff. During our visit, a person told us they were ready to die as they had achieved what they wanted; they could not remember staff giving them the opportunity to talk about death and their current feelings.

We recommend the providers and registered manager consult health professionals specialising in end of life care to ensure care and records are based on current best practice.

We checked an external review site as there were cards available for visitors to complete. This was to see if there had been recent feedback about the service or end of life care but comments related to 2015. The registered manager did not provide us with any compliments received by the service.

Most people looked relaxed in their surroundings and chatted to staff as they passed by them in corridors. A number of people chatted and joked with staff and the registered manager, showing that they felt at ease in their surroundings. On the first day of our inspection, one person who had moved in for an emergency respite stay laughed with staff. Two staff members had established a good rapport with them. On the following days of our visit, the person was less engaged with staff and appeared irritable. Care records and discussions with staff showed they had been unwell and were being treated for an infection.

Despite our concerns that some aspects of staff practice could improve, people were positive about their care. They told us they had a good relationship with staff. One person said "we all muck in together" and a second person said it was a "wonderful home". They said they could be quick tempered and staff gave them space and respected their privacy. Another person described the staff as "kind" and told us they wouldn't change a thing about their care. A fourth person spoke to us about the "friendliness of the home" and how everybody was an equal. A visitor said they had got a good feeling about the home as soon as they walked in the door, they said "see how caring they are to everyone, including me!" Another visitor described the staff as "fantastic" and that their relative "loved the staff to pieces". They said the staff really appreciated their relative's character and responded well to them. Other visitors also praised the caring nature of the staff and the welcome they received when they visited.

Staff said they would like more time to sit with people. People in the lounge spent time dozing or looking around them, although some chatted with each other. One person living with dementia gave a staff member eye contact and tried to take the staff member's hand but the staff member moved on without giving them eye contact. The person looked sad. Another person said they chose to spend their time in their room listening to the radio. They told us they did not feel isolated but we saw they had little interaction with staff unless it was task orientated, such as providing a meal or a drink. We met one person who was assessed by a health professional as liking company. However, no care plan had been completed by staff at the home to reflect this aspect of their character and their daily records showed no evidence of how this social need was met. We saw staff visiting their room to deliver care tasks. The person told us because of their visual impairment staff needed to introduce themselves when entering; some staff failed to adopt this approach.

People looked well cared for. Some people told us they received support with a shower or bath depending on their preference. People said they could have the support for the amount of times they requested, such as twice a week, although a bath rota indicated this support was planned rather than responsive. However, there was no record that one person who had lived at the home for ten days had been offered support with a bath or shower. Visitors to the home said they were happy with how their relatives were supported to maintain their appearance. For example, one person said their relative took a pride in their appearance and staff helped them to co-ordinate their clothing which was important to their relative's self-esteem. They said the staff "keep them spotless". Visitors said the laundry was well managed and clothing did not go missing. 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

Our findings

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'. However, there was not an effective system in place to assess and plan for peoples' care needs to ensure care and treatment was provided in a safe way. People were not being involved on a regular basis in the planning and delivery of their care needs. Monthly reviews were not meaningful. For example, they did not show or how people's social needs were being met. The home's statement of purpose said 'Family and significant others are actively encouraged to take part in care planning'. There was no record that people and/or their relatives were asked their views about the care and support provided at the care home. This was confirmed by our conversations with people and visitors.

When we looked at the existing care records we found these lacked personal detail about people's care and social needs. A number of people were staying at the home under respite arrangements. The registered manager told us people had been admitted as an emergency and they had not assessed people's care and emotional needs before they moved to the home. Some people had come direct from hospital and some from their own home. One person had lived at the home for approximately four weeks but a care plan had not been completed by staff at the home.

One person had moved to the home as an emergency respite on the registered manager's day off. They had not been assessed by a staff member from the home. A health professional had sent a care plan via e-mail with their care and emotional needs on it but the registered manager confirmed care staff had not been able to access this information until they returned to work the next day.

People told us they could get up and go to bed when they wished. We saw one person liked to go to bed between 10.30 – 11.30pm. Their daily records showed their personal preference had been respected. However, their night care records logged they could be 'aggressive' and uncooperative but there was no care plan to guide staff on their approach. There was no charts to help staff establish if there was a trigger to this behaviour to help them adapt their practice to avoid confrontation.

Records showed that people's hobbies and interests had not been assessed or recorded and this meant that people may be unable to pursue those interests. 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.

For people living with dementia there was little meaningful activity, which some staff commented on and

wanted to improve. The television was regularly left on but some people in the lounge said they had difficulty seeing it. For example, a person called out to a staff member "We can't see the television over here"; the staff member tried to angle the television for them to see but then others on the other side of the lounge said it was difficult for them to see. People told us time passed slowly. The registered manager said some staff had complained about the quality of an activity by an external entertainer. A number of people were in the lounge when the entertainer visited; their reaction was variable and most did not engage with the activity. Staff said there were few external entertainers that visited the home. There was a list of activities for each day on the wall of the hall but staff said these did not routinely happen. A visitor commented it would be good if there was "a bit more music". Their relative was living with dementia and became more animated when music was playing and they could sing along with the entertainer.

Care staff were expected to combine care tasks with providing activities; there was no staff role to specifically oversee how people's social needs were met. Staff were busy carrying out care tasks and they told us this impacted on their ability for staff to spend time with people to support their social needs. We reviewed daily records and saw there was poor recording of how people's social needs were met. For example, being in the lounge was recorded as an activity or there was no entry.

The above concerns are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's statement of purpose contained the home's complaint procedure but this was not displayed for visitors to the home who might not have a copy of the statement of purpose. Visitors were uncertain what documentation had been given to them when their relative had moved to the home but said they were confident that the registered manager would address any concerns. None had made a formal complaint. In 2017, anonymous concerns linked to the quality of care were investigated by the provider who interviewed staff. They did not uphold the complaint.

We recommend the complaints process should be clearly displayed and in a format that is accessible to people both visiting and living at the home.

Inadequate

Our findings

In March 2016, this service was registered with CQC under a new legal identity; this is the first comprehensive inspection in connection with the new legal identity. However, the registered manager and the provider have stayed the same.

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'. However, we judged there was no effective governance or oversight of the quality of the care and support in the home. This had impacted significantly on people's safety, well-being and emotional needs.

For example, lessons had not been learnt from a safeguarding alert made by a health professional linked to pressure care. We found that staff were following the advice given by visiting health professionals for this individual and had attended pressure care training. However, they had not then reviewed how they managed the pressure care of others. For example, monitoring people's weight and checking pressure relieving equipment was set appropriately to reduce risks of skin damage. Risk assessments were not fit for purpose. For example, assessments were completed regarding people's care needs but staff had not identified that these did not include pressure care risk assessments. We have contacted the local safeguarding team and the community nurse team with our concerns regarding pressure care and how risks to people's health is managed. It had not been identified by the registered manager or the provider that the system of recording people's weight was not effective. The registered manager was unable to demonstrate how the outcome of people's level of need influenced staffing levels.

Risk assessments relating to the environment were not meaningful. For example, a risk assessment stated that if the four stair lifts were not working staff must take immediate action but did not state what this action should be. Audits of the environment were not robust or systematic. For example, the registered manager randomly chose a room each month to sample the hot water temperature for the whole home. They said they were confident that staff would report environmental concerns but staff had not reported issues with two fire doors on the top floor or that two beds were badly stained.

The provider visited the home on a monthly basis. Records of these visits contained basic information. There was no audit trail of who they had spoken with. They did not check how records were completed, such as recruitment files. For several months it was recorded work on the seals of a fire door was needed; there was no action by the provider when this had not been completed. The registered manager said this information

was incorrect but had not requested for the provider to correct the audit record. However, the registered manager was unclear which fire door needed work on it and had not contacted the service company to clarify. They said they would now do this. We have contacted the fire service with the findings from our inspection. We identified concerns with some aspects of the environment which had not been identified by the registered manager or the provider. For example, poor infection control practice. The provider also did not ensure staff were responding to everyone's social needs.

There was not a commitment to formally gathering people's views on their experience of living at the home. For example, there had not been a recent quality assurance survey or regular meetings for people living at the home to share their views. The registered manager said they had ceased newsletters and reduced coffee mornings due to lack of feedback and poor attendance. People were not involved in development of their care plans or their monthly reviews, nor were people who were significant to them. However, 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.

Poor practice had not been identified by the registered manager or the provider. For example, poor infection control practice. Staff were not receiving regular and thorough training to meet the range of care needs of people living at the home. Staff told us that people's care needs were increasing and becoming more complex. They had not been supported appropriately to ensure their training gave them adequate skills to meet people's changing needs. Staff were not provided with sufficient training, knowledge and support to meet people's needs who were living with dementia, long term conditions and end of life care. Following our feedback some of this training was being organised.

The culture and the values of the service were not being assessed, monitored, and reviewed. Staff were not given the opportunity to influence the service, for example through an anonymous questionnaire. Staff meetings did not happen on a regular basis and some staff chose to opt out of the supervision process. There were no records to show staff practice was being observed and no record of a judgment of their competency, although staff member said they had worked alongside more experienced staff and had their skills observed. The registered manager addressed concerns when they were raised by health professionals but was responsive rather than proactive.

The above concerns are a breach of regulation 17 of the Health and Social Care (2008) Regulations 2014.

Notifications had been made to CQC regarding people who had died at the home and who have sustained a serious injury. Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service. The registered manager had not submitted notifications to CQC to cover all notifiable events in the home. For example, when a person had to be moved due to another bedroom as their bedroom ceiling needed replacing due to water damage and when a pressure sore deteriorated further.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because CQC had not been notified of incidents within the service.

Despite the above concerns, people living and visiting the home were positive about the friendly atmosphere of the home and the caring nature of the staff group and the registered manager. Staff members were positive about the way they worked together. A health professional commented that the registered manager was responsive to advice to improve the service. 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.

We asked staff for their views on their role and the service provided. One said they were "quite enjoying it" and liked caring for people. They said the staff team worked well together. Another said the team gave "good care – but the building is not the best." A third said things had improved in the last two years and the care was good but had "got harder". A fourth said the job was "not always easy, depends on who comes in – has got harder". A fifth was proud of the standard of care.

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 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of all notifiable events in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure staff understood their legal requirement to act in accordance with the Mental Capacity Act 2005 for those people who lacked capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who lived at the home were not protected against the risks associated with unsafe or unsuitable premises because of inadequate management of risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The recruitment process was not robust, which meant unsuitable staff might be recruited which could be detrimental to people's safety and well-being.

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was not an effective system in place to assess and plan for people's care needs to ensure care and treatment was provided in a safe and person centred way. People were not involved in the planning and delivery of their care needs.

The enforcement action we took:

Notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not been fully assessed and measures to reduce risks were not fully effective. People's safety was at risk. This was because people's physical safety and risks to their health were poorly managed.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks to people were not always managed safely. There were not effective systems to assess, monitor and improve the quality of the service.

The enforcement action we took:

Notice of proposal.