Sanctuary Care Limited

Wantage Nursing Home

Inspection report

Garston Lane
Wantage
Oxfordshire
OX12 7AR

Tel: 01235774320
Website: www.sanctuary-care.co.uk/care-homes-oxfordshire/wantage-nursing-home

Date of inspection visit:
17 February 2016
18 February 2016

Date of publication:
20 April 2016

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 17 and 18 February 2016. The inspection was unannounced.

Wantage Nursing Home is registered to accommodate persons who require nursing or personal care. The home offers care for up to 50 people. At the time of our inspection there were 39 people using the service.

There was not a registered manager at the service, however an application had been made by the current 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.

People were not safe. The service did not deploy staff effectively to meet peoples care needs. Call bells were not always responded to in a timely manner. People did not receive their medicines safely and medicines were not always secured.

People were not always protected from the risk of pressure area damage and choking, because thickeners were kept unsecured in communal areas of the home. The service had procedures in place to report incidents and accidents. However staff did not always follow these procedures. We observed poor standards in relation to infection control.

People's care plans did not always contain information that was guided by the principles of the Mental Capacity Act 2005 (MCA). Where mental capacity assessments had been carried out records were not underpinned on how best interest's decisions had been reached. Staff had completed training in relation to MCA but were not always able to understand the principles underpinning it.

The service had regular meetings in place for staff. However, staff told us and records confirmed that staff did not always receive effective supervision (one to one meetings with their line manager).

People were not always treated with dignity and respect. We observed that people were left in an undignified way during personal care. People's personal information was not always kept confidential.

People did not always receive personalised care. All the care plans held personal information about people including their care needs, likes, dislikes and preferences. However, guidance on peoples care needs was not always followed and records did not always reflect people's changing care needs.

We saw evidence that the service carried out monthly reviews of peoples care's needs. However, care records did not always contain accurate information. People told us and we observed that they did not always have access to a range of meaningful activities.

The provider had carried out quality assurance audits and had identified concerns within the home. However, the systems in place were not always effective.

The manager had visions and values for the home. However, these visions and values were not always displayed during the course of our inspection.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Staff we spoke with said they were confident they could raise concerns surrounding the day to day running of the service. However, staff did not always feel confident that their concerns would be acted on.

The adaption and design of the service did not always meet people's needs. We observed parts of the home where people were living with dementia were not decorated or designed in a way that followed good practice guidance for helping people to be stimulated and orientated.

People did not always receive their care and support when needed as there was limited equipment to assist people to transfer from, for example, their bed to a wheelchair.

Staff told us and records confirmed they received training. However, we identified three staff members that were responsible for administrating medicines were overdue in their refresher training. Medicines administered 'as and when required' included protocols providing guidance for staff about when the medication should be used. Staff had an understanding of the protocols and how to use them.

People who needed assistance with eating and drinking were mainly supported appropriately. However, people who had been assessed as being at risk of becoming malnourished or dehydrated were not always supported appropriately.

A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, district nurses, speech and language therapists (SALT) and other professionals from the Care Home Support Team. The service worked in partnership with visiting agencies. During our inspection we observed positive interactions with visiting healthcare professionals.

The service sought people's opinions through a yearly satisfaction survey and a quality assurance questionnaire.

People and relatives were complimentary about the staff and told us staff were caring. People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. We observed some kind and caring interactions.

Staff we spoke with had knowledge of types of abuse, signs of possible abuse. Staff were aware of how to report safeguarding concerns internally and externally. Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events.

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

The 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. Call bells were not always responded to in a timely manner.

The service did not deploy staff effectively to meet peoples care needs.

People did not receive their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always receive effective supervision.

People's care plans did not always contain information guided by the principles of the Mental Capacity Act 2005 (MCA).

People who had been assessed as being at risk of becoming malnourished or dehydrated were not always supported appropriately.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect and people were kept waiting when they needed care assistance.

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive personalised care.

People's care plans did not always reflect their changing care needs.

People did not always have access to a range of meaningful activities.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had quality assurance audits in place. However, we had identified safety issues which had not been identified through these audits.

Records were not always complete or accurate. We saw people's personal information was not always kept confidential.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice.

Wantage 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 18 February 2016 and was unannounced. This inspection was carried out by three inspectors, one pharmacy inspector and a specialist advisor, whose specialism was nursing.

Before the visit we 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. We spoke with local authority safeguarding and contracts teams. We also sought the views of two healthcare professionals.

We spoke with 10 people who were living at Wantage Nursing Home. We also spoke with five people's relatives. Not everyone we met was able to tell us their experiences, so 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 talk with us.

In addition we spoke with one activity coordinator, one member of kitchen staff, three nurses, seven care workers, two visiting professionals, the deputy manager, the general manager, the area manager and the regional manager. We looked around the home and observed the way staff interacted with people.

We looked at 11 people's care records, and at a range of records about how the home was managed. We also reviewed feedback from people who had used the service.

Inadequate

Is the service safe?

Our findings

People told us there were not enough staff. Comments included "They are very short staffed, sometimes you have to lay in bed, sometimes it can be eleven or twelve o'clock before they get you up", "The staff are always grumbling that there's not enough staff" and "I can wait half an hour or an hour to come and put me on the toilet".

Relatives we spoke with told us: "There's not enough staff, they could do with one more", "They haven't got the time that's what it is", "Some days there's just not enough staff, they always seem to be at a minimum", "They just haven't got enough staff to go around" and "There have been occasions where I have had to go looking (for staff)".

Staff told us they did not have enough staff to meet people's needs. Comments included: "We are always short staffed", "Our staffing is shocking", "We end up rushing personal care and it feels like we are neglecting our clients. That's not why we do this job", "We end up getting grief for things we physically can't do", "The dependency of residents against the quota of staff is not enough", "It is impacting on the quality of care" and "There's not enough staff".

People had to wait for long periods of time for support from care staff. For example, one person who was waiting for their call bell to be responded to told us "This can go on for half an hour". We sat with this person to observe how long it took for staff to respond. Whilst the call bell was ringing we saw one staff member walk past the person's room without checking on them. After 16 minutes a staff member responded to the call bell. We observed on another occasion a person's call bell was ringing for 20 minutes, as there had been no response a member of the inspection team alerted the manager. The call bell was then responded to. Whilst the person was waiting for their call bell to be answered we checked to make sure the person was not at immediate risk or distressed. During this time we observed two different staff members walk past this person's room without checking on them.

We observed throughout our inspection that care staff on both floors were often rushed and did not have the time to meet people's needs. For example, one person required support with their continence needs. We observed this person waited for two hours and 45 minutes and no care staff came to attend to this person. Due to the amount of time this person had been left requiring support we alerted the manager. The manager informed us that this person did not require continence support. However, through further observations we identified a satisfactory check had not taken place. This was confirmed by staff who told us that assistance was given following the managers check and the person was in need of continence support.

One visiting professional told us they were recently supporting someone and required staff assistance to help the person get to the toilet. However, they were told by a staff "We are too busy, they will have to wait".

We spoke with the manager and the regional manager about our concerns surrounding the staffing levels and the lack of response to peoples call bells. Both the manager and regional manager gave assurances that this would be addressed immediately with staff. Following our inspection we received evidence that the

provider had since addressed this with staff and had developed an action plan to address these issues further. This included a review of staffing levels.

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

People were not always protected from the risk of pressure area damage. Where people had been assessed by nursing staff as at risk of pressure sores, care plans and risk assessments were in place. However, records relating to the repositioning of two people showed they had not been repositioned for long periods of time. For example, one person's records stated they had remained on their left side for 10.5 hours on 15 February 2016. Another person's records stated they had remained on their back for 6.5 hours on 17 February 2016. One relative we spoke with raised concerns that during a recently busy day at the home, their relative's records stated that they had not been supported to reposition themselves for nine hours. These timeframes for helping people to change their position exceeded those recommended in national guidelines. Staff we spoke with could not confirm that people had been repositioned. This meant people were at risk of developing pressure sores.

People were not always protected from the risk of choking. Two people were prescribed thickener for their drinks. The thickener was not always stored safely. For example, we observed the thickener was kept in communal cupboards that were accessible to people on the dementia floor. The manager was not aware of the national safety patient alert surrounding the safe storage of thickeners. Patient safety alerts are a crucial part of the NHS to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.
The service had procedures in place to report incidents and accidents. However, staff did not always follow these procedures. For example, we observed an accident were a person with poor skin integrity on their feet had a table dropped on their feet by a staff member. This caused the person a great deal of pain. On the second day of our inspection we spoke with the manager and saw this incident had not been raised through the appropriate system and the manager had not been made aware of the incident. This put people at risk because no learning from this incident had been shared to prevent it from happening again.

People were not protected against the risk of the spread of infection. For example, we observed and staff confirmed that only one hoist sling was in use on the Carlton suit. This hoist sling was used to support 12 people. We were informed by staff this sling was used for all lifting tasks and included supporting people to the toilet. One staff member we spoke with told us "People don't have their individual slings this is not good infection control. This has been going on for a while". The use of one sling not only presents a risk in relation to infection control but also increases a risk of harm to people. For example, if the sling is too small it can result in discomfort to the person, if it is too large, the person may be at risk of slipping through the sling.

Staff were aware of the providers infection control policy and procedures. Records showed that staff had received training in infection control. Staff wore protective clothing when required. However, staff we spoke with told us there was sometimes a lack of appropriate protective clothing available. For example, one member of staff we spoke with told us "I have had to go to the hospital across the road three times to borrow gloves". Another staff member felt there were enough gloves. However, they were not always the correct size. We raised this with the manager and they told us that this would be addressed.

The environment had areas that were not always clean. For example, during our inspection we found chairs and the carpet in the main lounge of the Charlton suit were soiled. We raised this with the manager who arranged for the marks to be removed immediately.

People did not receive their medicines safely. For example, we observed medicines were administered up to two hours after the prescribed time. Staff we spoke with told us that this was a routine occurrence. The impact of this was people may have doses of their medicine too close together and this may put the person at risk of over medication. Medicines were not always secured safely. For example, we observed how one person's medicine was left unattended on a medicine trolley by a staff member as they left the area and went into a person's room and closed the door during a medication round.

We spoke with the area manager and the regional manager about our concerns surrounding medicines and infection control. They gave us assurances that this would be addressed immediately within the service. Following our inspection we received evidence that the provider had taken action to address these concerns. However, this was not in place on the day of our inspection.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines administered 'as and when required' included protocols providing guidance for staff about when the medication should be used. Staff had an understanding of the protocols and how to use these to ensure people received the correct amount of 'as required' medication.

People we spoke with told us they felt safe. Comments included "I feel safe", "If you said am I happy here, is everything o.k. then I would say yes" and "Yes I am safe here". One relative we spoke with told us "Yes based on my gut feeling [relative] is safe".

Staff we spoke with had knowledge of types of abuse, signs of possible abuse, which included neglect and their responsibility to report any concerns promptly. Staff members told us they would document concerns and report them to the nurse, manager or the provider. Comments included: "I would go straight to my manager", "I would report it to the nurse in charge of the floor and tell the manager", "If I couldn't get hold of my manager then I would report it to the area manager". Staff were aware they could raise concerns outside of the organisation. One member of staff told us "I would call the police, social services, the doctor's or the CQC (Care Quality Commission)".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. The manager told us "No one starts without a full DBS".

Requires Improvement

Is the service effective?

Our findings

People's care plans did not always contain information that was guided by the principles of the Mental Capacity Act 2005 (MCA). The MCA sets out what must be done to make sure the human rights of people who may lack the capacity to make some decisions are protected. Care plans did not always contain clear information relating to people's capacity to consent to care. For example, not all care records evidenced that where people who required an assessment had received one. Where mental capacity assessments had been carried out the principles of the MCA had not been followed as it was not clear from the records how best interest decisions had been reached.

One person had been assessed as lacking capacity about making decisions relating to medicines and received their medication covertly, for example the medicine needed to be mixed in with their food or drink without them knowing it was there. The details in this person's care plan contradicted the principles of a best interest decision under the MCA. In this persons care records it stated that staff needed to respect the person's decision not to take their medicines. However the best interest decision details in the care records showed that this person needed to receive their medication.

Staff had completed training in relation to MCA. However, they were not always able to understand the principles of the Act. For example, we spoke with two members of the nursing staff who were unable to explain how an assessment of capacity should be carried out. The staff members told us that they knew about the act but did not feel confident in implementing it in practice. Both staff had responsibilities for carrying out the MCA assessments.

Deprivation of Liberty Safeguards (DoLS) provide legal safeguards for people who may be restricted of their liberty for their own safety. We saw the service had identified people who may need to be deprived of their liberty and made applications to the supervisory body. However, not all staff we spoke with were aware of who had DoLS in place. This meant staff were at risk of depriving some people of their liberty without the legal right to do so.

We spoke with the area manager and the regional manager about our concerns surrounding MCA and DoLs. We were assured that this would be addressed immediately within the service. Following our inspection we received evidence that the provider had taken action to address these concerns.

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

Staff did not always receive effective supervision (one to one meetings with their line manager).The manager informed us that supervision meetings should take place "Every two months". However, care and nursing staff told us they did not always receive supervision. Comments included "I don't really get supervision", "By not having supervision it makes me feel devalued", "Supervision is infrequent" and "I never seem to get it (supervision)". One staff member we spoke with described having to wait for long periods of time without supervision. We looked at supervision records for four staff members which confirmed this. For example, one

staff had worked with the service since 2008. However, they had only received three supervisions during this time, the last one being in July 2013.

The provider's policy on staff supervision stated 'Five meetings a year must be for supervision'. We discussed this with the manager who informed us that they were aware of this and that this was included within a recent service improvement plan. This included the implementation of schedules and matrix's that would be aligned to organisational policy. However, this was not in place on the day of inspection.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had a range of training to meet people's needs and keep people safe including safeguarding adults, moving and handling, medication and health and safety. Staff gave a varied response about the training they had received. Comments included: "The training is good, it keeps you up to date", "The training has improved but I could do with more hands on training. At the moment it's all done on a computer", "The training gets a bit repetitive, but it's better than no training". Staff we spoke with also confirmed they had to undergo refresher training to ensure they still had the competencies required to deliver certain aspects of peoples care. However, we identified that three staff members that were responsible for administrating medicines were overdue in their refresher training by 3 months. The impact of this is that people where receiving their medicine from staff who had not had their competences checked. We spoke with the manager about this who confirmed they were aware of this and had attempted to arrange training from a local pharmacy. However, this had not taken place at the time of the inspection. People who had been assessed as being at risk of becoming malnourished or dehydrated were not always supported appropriately. For example, one person's malnutrition universal screening tool (MUST) chart recorded 'Unable to check weight due to lack of equipment'. Another person who was at risk of dehydration had their fluid intake recorded. However we noted their intake was consistently low. Staff were unable to confirm if peoples records were accurate. Comments included "You're relying on carers to do their job" and added "I can't tell you when [person] was last checked".

On the day of our inspection we observed people had sufficient to food to eat. We asked people if the food was sufficient. The response was varied comments included "The foods alright", "There's not a lot of choice", "You get enough", "The foods (not good)"and "The breakfast is good". However some people told us they did not always have the choice of the food they preferred.

Where people needed assistance with eating and drinking they were supported appropriately. People were offered a choice of two meals on the daily menu. However, relatives we spoke with told us they had concerns about their family member's food intake and nutrition. One relative told us they were concerned their relative had been losing weight and care records stated 'declined food'. They told us that their relative would eat sufficiently as long as they had enough time and encouragement. The relative told us that as a result of this they now came in to support the person at meal times.

On the first day of our inspection we noted that all the people residing on the nursing unit had their doors opened. We queried this with the manager because we were concerned about people's dignity and respect. The manager informed us "Everyone has been asked if they want their door open". We asked if this preferences would be evidenced in care records and we were informed "Yes it is" by the manager. However, we found no evidence of this in care records. People we spoke with gave a mixed response to having their door open and people we spoke with told us this had not been discussed with them. On the second day of our inspection we were informed by staff the manager was in the process of updating this information on people's preferences into care plans. However, we checked with one person who told us that no discussion

had taken place.

The adaption and design of the environment did not always meet people's needs. We observed parts of the home where people were living with dementia were not decorated or designed in a way that followed good practice guidance for helping people to be stimulated and orientated. We discussed the decor and design of the dementia unit with the manager. They were able to provide us with evidence that this had been highlighted to the provider and they were awaiting a response about refurbishment plans.

A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, district nurses, speech and language therapists (SALT) and other professionals from the Care Home Support Team. One healthcare professional told us staff sought their advice when necessary. Where people had been identified as having swallowing difficulties referrals had been made to SALT. Care plans contained details of recommendations made by SALT and we saw staff had followed these recommendations.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect as we saw that most of people's bedroom doors were left open. For example, we observed how one person was left unattended with their door open during personal care. On another occasion we observed a person was not fully clothed and they had their bedroom door propped open with a trolley, which exposed them to people in the corridor. We raised this with the regional manager who took immediate action to promote the person's dignity and gave assurances that this would be addressed with staff.

We observed that on occasions staff would call out to people if their room doors were open before they walked in, or knocked on doors that were closed. However, we witnessed one occasion were a staff member entered a person's room without letting them know. This did not display that staff respected people's dignity.

Another person's relative had highlighted to staff the person needed to go to the toilet. We observed that this person had been sat in the same chair for 15 minutes without any staff interaction. When a staff member did go to attend to this person, they were told by a senior member of staff to "Concentrate on (giving out) food". This meant this person was not assisted to the toilet which may put them at risk of not having their dignity upheld.

We observed people sat for long periods of time with no interactions from staff. We saw staff did not always have time to speak with people and explain what they were doing before supporting people. For example, we observed one member of staff who was ensuring that people had protective covers for their clothes during meal times. They walked up to a person and without explanation stated "Put your hands on the table". The person did this and the staff member put the protective cover on them and walked away with no further interaction or explanation.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff who were knowledgeable about the care people required and the things that were important to them in their lives. Staff spoke with people about their family and where they had lived. For example, one member of staff was able to tell us details about a person's history and their family. We checked with the person and their care records that confirmed this. However, some staff did not always feel they had enough time to read people's care plans in order to increase their knowledge about the people they were supporting. One staff member told us "You don't get time to read and go through people's care plans". One person we spoke with told us they were provided with choices and their care was provided "In a way that they liked it done". This person also told us staff listened to them and provided care according to their preferences.

People were complimentary about the staff and told us staff were caring. Comments included; "The girls are always very nice and helpful", "They are good staff", "Oh yes they care", "They always support me, the last

thing they want me to do is have a fall", "The staff are good", "We always have a little laugh", "They are good staff", "On the whole staff are good. They get to know you", "I'm very pleased to be here" and "The staff are caring". Relatives we spoke with were complimentary about the staff. One relative said "The Staff are excellent.

We observed some staff displayed kind and caring interactions with people. For example, one person who did not wish to eat anything was supported by a staff member who encouraged them to consider a different choice of food. The person agreed to this and the staff member arranged for a different meal choice to be offered. The staff member then supported the person in a caring way to eat their meal.

We saw some good practice to support people at mealtimes. One person who was having their breakfast was supported by a staff member that was encouraging them to eat. The staff member explained the importance of having their breakfast and made sure the person was sat up in the right position. The person was clearly happy with the support from the staff member.

People were spoken to mostly in a respectful way and used the person's preferred name. When staff spoke about people to us or amongst themselves, they were respectful. Important friendships were maintained as people's friends and relatives could visit whenever they wanted to. People had the choice to meet their relatives in the communal areas or in the privacy of their rooms. People had their own bedrooms which enabled them to maintain their privacy. Staff we spoke with told us people were encouraged to personalise their rooms. Rooms we observed had been personalised and made to look homely.

Care records highlighted people's faiths and religious preferences. For example, one person's care records highlighted their individual religious needs and how the person enjoyed them. We spoke with a member of staff about this person and they knew the person's preferences. We observed evidence of how the service had made arrangements for a local priest to attend the service to ensure the religious needs of people with mobility issues could be met.

We observed compliments that relatives had sent the service thanking them for the end of life care their relatives had received at the service.

Requires Improvement

Is the service responsive?

Our findings

All the care plans held personal information about people including their care needs, likes, dislikes and preferences. However, guidance on people's care needs was not always followed. For example, one person had in place a behavioural management plan. Guidance for staff stated '[Person] gets angrier if staff try to explain or give reasons'. The guidance staff should follow in these incidents was to give the person time and space to calm down before giving reasons and that "Staff should avoid confrontation". We observed an incident were this person became angry and agitated and a staff member tried to give the person an explanation and a reason around their behaviour. This made the person more agitated and angry. This approach by the staff member did not follow guidance in this person's care records. This meant this person's needs were not being responded to in line with their care needs.

People's care plans did not always reflect their changing care needs. For example, one person's care records highlighted that they needed a walking aid to support their mobility. However, when we spoke with staff about this they informed us the information in this person's care records was incorrect. Because the person was cared for in bed and needed a full body hoist to support with transfers. Another person's care records had recently been updated to include additional guidance on moving and handling. This update included guidance to staff that the person needed hourly checks to ensure their safety. However, we spoke with three members of staff on duty who were not aware of this guidance. We attended the handover meeting on 18 February 2016 and this update was not discussed at the meeting which meant important information was not relayed to staff which could have impacted on this person's safety.

We saw evidence that the service carried out monthly reviews of people's care needs. However, care records did not always contain accurate information. For example, one person's care records stated they needed to be repositioned every four hours to protect their skin integrity. The care plan provided guidance on how the person should be moved and positioned. However, when we spoke with staff about this they informed us that the person needed support to reposition themselves every two hours in order to maintain their skin integrity. This did not correlate to the guidance in this person's care plan. This meant the person was at risk of not having their skin integrity maintained.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that the service was using one hoist to support 12 people on the dementia unit. This meant that people had to wait for long periods of time before they could be supported appropriately. For example one person who required a hoist to move from their wheel chair to a lounge chair waited 55 minutes for the hoist to arrive. When staff finally supported this person to move to the lounge chair they were not given a choice of where they would like to sit. The staff member told the person "We will sit you in that chair". This meant the person did not have a choice had their preference respected.

The manager told us an activity co-ordinator worked at the home and provided activities for people on both floors of the home. However, people did not speak positively about the activities. Comments included

"There's nothing to do, I get to do a bit in the garden, but that's it", "They are (activities) not my kind off activities" and "There is nothing to do".

Staff we spoke with said that there needed to be more activities in the home and there should be more variety for people. Staff comments included "The lack of activities is hideous", "There's an activity's person but there doesn't seem to be much activity going on" and "(the activities) are quite rubbish". When we spoke with the activity coordinator they told us "We have improved since September (2015), but there's a lot more improvements that need to be done".

We observed that the home had recently had a Valentine's day event, Burns evening and a community bingo event. However, one relative we spoke with told us that they did not feel that the valentine's event was "all inclusive" and described how one of the lounges had been allocated for the Valentine's day event, which meant not all the people in the home were able to access the celebration. One person and their family had commented how his had upset them as the event was not inclusive for all the people at the home.

The service sought people's opinions through a yearly satisfaction survey and a quality assurance questionnaire. This was given to people, relatives and staff. We observed that the responses to the survey were satisfactory.

Requires Improvement

Is the service well-led?

Our findings

The provider had recently carried out a quality assurance audit and had identified concerns in the home regarding staff supervision, training and care plans. However, issues uncovered at our inspection had not been identified through these audits. Issues included, response time to call bells, infection control and staffing levels. This showed systems operated by the home were not effective. We were also informed by the manager that a monthly competency check had been introduced for staff relating to the MCA. However, on speaking with some staff it as clear their knowledge of the MCA had not been properly checked to ensure they were competent and could apply the principles of the MCA.

Staff we spoke with said they were confident on how to raise concerns. However, they did not always feel confident their concerns would be acted on. For example, staff told us they had repeatedly asked for new thermometers as some of the existing ones did not work. However, at the time of our inspection this request had not been acted upon.

We observed that people's personal information was not always kept confidential. For example, we saw on two occasions people's care records were left out in an unoccupied office which was accessible to anyone as the door was not locked. This office was situated in a part of the home that people and relatives had access to. We raised this with the manager who informed us that this office should have been locked using the keypad provided.

Throughout our inspection we saw evidence that records were not always complete or accurate. For example, one person who was assessed as lacking capacity had a care record that demonstrated the last care review was in June 2013. However, we saw evidence that this person received regular reviews for their care. Another example was that repositioning charts had not been completed accurately as they did not record the frequency in which people were repositioned. Neither of these issues had been identified through the providers' quality monitoring system.

We spoke with the manager about this who told us "I know staff here are delivering good care, but I need to be assured that it is evidenced" and "They are doing it but they are not recording it".

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

There was not a registered manager at the service. The manager told us they were in the process of registering with CQC. The service had management arrangements that included a manager and a deputy manager.

Some people spoke positively about the manager. One person we spoke with told us "She always says hello, I like her". One staff member we spoke with told us "They are very approachable". However, some people and staff did not always feel that the management of the home was responsive. Comments included "The managements not good", "They listen but they don't do anything about it", "They need development" and

"The manager doesn't always answer your questions".

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, district nurse and Care Home Support Service. During our inspection we observed positive interactions with visiting healthcare professionals. However, one healthcare professional we spoke with told us "The service is receptive but they don't always follow things up".

The manager told us the visions and values of the service were "To have real person centred care delivered here, it's about involving other people". It was evident from speaking with staff they shared the same visions and values. However, these visions and values were not always displayed during the course of our inspection. For example, guidance in peoples care plans was not always followed.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of reportable events.

Staff told us that regular staff meetings were held. The service manager told us these were used to "Make sure that staff have support", "To discuss safeguarding" and "Look at clinical aspects (of the service)". We observed a handover meeting that was relaxed and staff were able to feedback on their areas of work, although not all of the changes to people's needs were discussed. We were also shown evidence that the service had implemented an evening meeting for staff who worked the night shift to ensure all staff had access to updates and developments regardless of which shift they worked.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of service users was not always person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Service users were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not provided care with the consent of the relevant person. The provider had not acted in accordance with the principles of the mental capacity act 2005 and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems in place were not always effective. Records in relation to service users were not always complete or accurate.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Persons employed by the service provider have not been appropriately supported.

This section is primarily information for the provider

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always provide care and treatment in a safe way for service users.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have sufficient numbers of suitability qualified, competent, skilled and experienced persons deployed in order to meet the requirements and people's needs.

The enforcement action we took:

Warning Notice