Care Quality Commission

Sanctuary Care Limited

Wantage Nursing Home

Inspection report

Garston Lane
Wantage
Oxon
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Wantage Nursing Home provides nursing care and support for up to 50 older people including those living with dementia. At the time of our inspection there were 47 people living at the home.

Wantage Nursing Home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This unannounced inspection took place on the 26 February 2015 with an announced second visit on the 4 March 2015. At our last inspection of Wantage Nursing Home in November 2013 we found the home met all the regulations assessed.

Summary of findings

There was significant dissatisfaction with the quality of the food.

People were positive about their safety and security. Potential risks to people's safety were identified within their care plans. For example, from falls. Action was taken to address this, falls risk assessments identified the number of staff and equipment required to move the person safely.

The interaction between staff and people living in the home was polite, respectful and friendly. There was a very relaxed atmosphere throughout the home and staff had time to talk informally to people in lounges and dining areas.

People had different opinions about staffing levels. Some people said there were always sufficient staff available others said that at times there were not. We checked staffing rotas on the days we visited and found they agreed with the set staffing structure. The provider told us they kept staffing under review and adjusted staffing levels according to the number and dependency levels of people. However, some people told us they did not feel the dependency level was always appropriately reflected in staffing levels. There was very little recent staff turnover which helped provide consistency of care for people.

Staff confirmed they received regular training to enable them to meet people's care needs. Domestic support staff confirmed they had received infection control training and training about the safe use and storage of chemical products.

Staff confirmed there was a mixture of formal and informal supervision, together with an annual appraisal. There were staff meetings and staff felt able to discuss any issues with their line manager or the registered manager.

Staff had received safeguarding adults training and this was confirmed from training records. There was safeguarding information and contact details displayed prominently in the home for staff and others to refer to. Staff gave us examples of what kinds of abuse they might see and how they would recognise it. They were able to describe the action they would take to protect people and how they would report any suspected abuse.

Care plans included evidence of pre-admission assessments to identify individuals' care needs. This enabled, for example, any specific equipment required to be put in place before the person moved in and ensured their needs could be met from the outset. Staff followed any advice and recommendations given by healthcare professionals involved with the service, for example GPs and specialist nurses. Care plans were kept under review and care staff were aware of the relevant details and acted upon them.

Medicines were administered safely. Routine checks were carried out to monitor records and practice to make sure people received safe and effective support when they needed help with their medicines.

Relatives confirmed they had completed annual questionnaires and could also meet informally with the registered manager to discuss their relative's care and provide feedback.

Staff had a good understanding of the implications for them and their practice of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People received the care and support they required.

People were supported by staff that had been subject to a robust recruitment process.

People were protected from the risk of injury or harm because there was an effective system in place to identify, eliminate or manage risks to their health safety and welfare.

Good

Is the service effective?
The service was not wholly effective.

People were at risk of not having their nutritional needs met as the food was not consistently to their taste or appetising.

People's day to day health needs were met.

People received care from staff that were appropriately supported through training and supervision.

Requires improvement

Is the service caring?
The service was caring.

People were treated with respect and their privacy and dignity were protected.

People were supported by an effective system of care planning, review and recording.

People and those responsible for them were appropriately involved in decisions about the planning and delivery of their care.

Good

Is the service responsive?
The service was responsive.

People were asked how they wanted to be supported and this was acted upon.

People were able to make comments, compliments and complaints about the service either formally or informally.

People were supported to take part in activities within the home and community, in order to meet their need for social activity, stimulation and entertainment.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

People benefitted because the service reviewed its day to day operation and monitored its activity. People who lived in Wantage Nursing Home, staff and relatives could influence the way the service operated. They were provided with opportunities to communicate their views and were asked for their assessment of how the service was run.

People's care was more effective because staff were supported in carrying out their roles and had opportunities to discuss any issues or concerns with the management team of the service.

People received co-ordinated care because the service worked with and took account of the views of partner organisations, including the local authority and local health services.

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 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 inspection took place on the 26 February 2015 with an announced second visit on the 4 March 2015.

The inspection team included an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case older people's services.

Prior to our visit we reviewed the information we had about the home. This included any concerns raised with us on behalf of people who lived in Wantage Nursing Home. We contacted social care and healthcare professionals with knowledge of the service. This included two GPs, the NHS Care Home Support team, people who commission care on behalf of the local authority and two social care professionals responsible for people who lived in Wantage Nursing Home.

During the visit we spoke with six people living at the home, nine relatives and nine members of staff including nurses, care staff and domestic support staff. We also spoke with the registered manager and a senior manager for the provider. We observed care and support in lounges and dining areas and with their permission people's rooms. We looked at six care plans, five medicines records, three recent staff recruitment files and summary records of staff training and supervision undertaken by all care and nursing staff. We also looked at quality monitoring processes and reports undertaken by the provider.

Good

Is the service safe?

Our findings

We found conflicting views about staffing. Prior to our visit concerns were raised with us about staffing levels. During our visit four people who lived in the service said they felt there were not always sufficient staff available. One said; "Carers are very good at what they do, but they do not always have the time they need." One person said they thought the home was short-staffed about 25% of the time and a relative told us; "They can be noticeably short-staffed which means longer waits to answer call bells and rushed care".

Three members of staff said they were short-staffed at times, with one putting it at 60% for the first floor. They told us this meant they did not always have the time to spend with people they would like to have and thought they needed. One member of staff said they felt the lounges could be neglected at times which had implications for people's safety. One of the health care professionals who provided feedback said they had noticed the lounges were not always staffed when people were in them and felt the high dependency levels of people who lived in some parts of the home were not always reflected in staffing levels.

However, three members of staff said whilst staffing had been a problem, this had recently improved. People who commissioned care on behalf of the local authority reported that between June and October 2014 they found staffing levels and staffing ratios had improved. Staff were undoubtedly busy and told us they would like to be able to spend more time with people than they were usually able to do. However, on the days of our visits we checked staffing rotas and found they agreed with the set staffing structure. We were told by the senior manager present that they kept staffing under review and adjusted staffing levels according to the number and dependency levels of people. The registered manager informed us they monitored the weekly need for staff and made adjustments, for example in the number of nurses or senior care staff deployed at any one time. The need for the use of agency staff had been significantly reduced and was said to now be; "Only occasional," for example, on the week of our first visit only one agency member of staff was required on one day.

People were positive when asked about their personal safety and security and no concerns were expressed about the safety of the premises. One relative told us their relative "never complains but she feels she is fairly safe here."

Potential risks to people's safety were identified within their care plans. For example, from falls or damage to the person's skin from pressure. There were control measures put in place to eliminate or manage risks where that was possible. For example, falls risk assessments identified the number of staff and equipment required to move the person safely and pressure relieving equipment was identified and put in place to protect vulnerable skin areas.

Staff had received training in infection control. They followed good practice, for example we saw they wore appropriate protective clothing when providing care. This helped protect people from the risks associated with acquired infections.

People were protected from abuse. Staff confirmed they had received safeguarding adults training and this was confirmed from training records. Staff were able to talk with knowledge about what might constitute abuse and what they should do if they saw or suspected it. There was safeguarding information and contact details displayed prominently in the home for staff and others to refer to. The provider had taken action to safeguard people within the home. For example by making safeguarding referrals where appropriate.

People received their medicines safely. We checked three people's medicine records which were accurate. We looked at arrangements for the storage and disposal of medicines and found they were safe. The expiry dates for medicines were checked and temperatures of medicines storage were recorded to ensure they were within recommended limits. Senior staff carried out regular medicines audits to monitor and support good practice and ensure people's safety.

Regular maintenance schedules were in place for equipment to ensure it remained safe to use.

We looked at service records for fire extinguishers and found they had been serviced to ensure they remained operationally effective in the event of fire. Staff had been trained in fire safety.

Staff were provided with training in the safe use of hoists and other equipment used in the care of people. We were told there had previously been some delays experienced in obtaining the correct hoist slings for people but this had now been addressed.

There were effective staff recruitment processes in place to safeguard people from the employment of unsuitable staff

Good

Is the service safe?

to provide their care. We looked at the recruitment files for recently recruited staff. We found appropriate checks had been undertaken before they commenced work. These included written references, full employment history with gaps accounted for, satisfactory Disclosure and Barring Service (DBS) checks to identify any known criminal record and health screening.

Requires improvement

Is the service effective?

Our findings

People were not satisfied with the current standard of food provided. We received a significant number of adverse comments about the quality of the food which suggested there had been a recent deterioration in quality. "The food used to be lovely – now it is lousy" was one relative's comment. One person who lived in the service said they thought the home seemed to have problems with chefs and hoped things would improve as the food was "appalling". Another person said the chefs did not "understand about what older people like" and felt the mashed potato in particular was "lumpy and not at all nice". Another person said; "Meals were a bit hit and miss and more miss at the moment" they said the taste and presentation of food were not what they expected from the menu. We tasted the main meal of pork casserole. We found the mashed potato was very lumpy and rather dry, the pork was bland and the casserole was made with tomato based sauce and the serving we tasted was quite bitter. The alternative of quiche did not to our taste have much flavour and the vegetables appeared over-cooked.

One person said they found communication between staff was not always; "As good as it could be". They said this was because in their view there was a lack of staff consistency, and staff were moved from one floor in the home to another.

Four people said communication with staff could be an issue. They thought this was because of a "language problem". One relative said her relative had a problem understanding those care workers for whom; "English is not their first language." One relative told us the home were very good at calling her and informing her of any significant events involving their relative. Another relative confirmed they had been quickly informed when their relative had a fall, although not when they were a bit unwell for a few days, on the whole though they felt sure they were told about any; " Important developments".

The mealtimes we observed were quite informal and relaxed. People were able to eat at their own pace. We saw relatives were able to sit with their family member and in several cases were actively supporting them to eat. Staff were aware who needed assistance and whilst this was given discreetly there were delays experienced by people waiting for help with their food. Additional staff did help, for example we saw activity staff assisting people in one dining area.

Care plans included evidence of pre-admission assessments to identify individuals' care needs. This enabled, for example, any specific equipment required to be put in place before the person moved in and ensured their needs could be met from the outset. The initial assessment process also included a nutritional assessment which identified any risk factors such as a history of weight loss or swallowing difficulties as well as establishing any dietary requirements. This could include people who were diabetic or who needed their food thickened to assist them to swallow food safely.

Specialist healthcare professionals confirmed they received appropriate referrals from the service. They said co-operation and co-ordination with them was good, which benefitted people living in the service and meant they had ready access to the health service advice, support and treatment they needed.

Previous to our inspection, concerns had been raised about the recording of staff training and the provision of staff training in dementia care and the Mental Capacity Act (2005) (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. When people are assessed as not having the capacity to make a decision themselves a decision is taken by relevant professionals and people who know the person concerned. This decision must be in the 'best interest' of the person and must be recorded.

The Care Quality Commission (CQC) monitors the operation of the DoLS as they apply to care services. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely. There were 34 DoLS applications outstanding at the time of the inspection. The management of the service were aware of the implications for the potential increase in applications as a result of a recent Supreme Court judgement which widened and clarified the definition of what constitutes a deprivation of liberty.

We were told these concerns about MCA and DoLS training had been addressed and we saw an updated training plan

Requires improvement

Is the service effective?

dated 27 February 2015 which confirmed this. The staff we spoke with had a good understanding of the implications for them and the service of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

The training plan also detailed other training provided and showed the outstanding training required by staff and when it was to be provided. Significant amounts of training were provided through e-learning (computer systems based) which was assessed and monitored. We saw an example of how this was done, with the status of individual staff members' progress with each topic and how often they had logged in recorded.

Staff confirmed they received regular training to help them meet people's care needs. New staff had been given appropriate induction training This meant they knew what was expected of them and were given the knowledge, skills and support they needed to carry out their specific role. For example, domestic staff confirmed they had received infection control training and training about the use and storage of chemical cleaning materials which could be hazardous to people's health.

Training records included periodic updates where this was judged as necessary by the provider; for example moving and handling and safeguarding along with others.

People received support from staff who felt well-supported. Staff confirmed there was a mixture of formal and informal supervision, together with an annual appraisal. Staff felt they had the support they needed and also felt able to approach senior staff and the manager at any time if they had a problem or needed advice on a specific matter. We saw from a supervision matrix that staff supervisions were planned ahead and recorded once completed. Supervision and appraisal training was planned to take place for appropriate staff in April 2015.

The premises were suitable for the people who lived there. People had access to the aids they needed to promote their independence and staff had the equipment needed and training provided in its use, where assistance was required. For example, when bathing people or assisting people to move within their rooms or around the home.

Good

Is the service caring?

Our findings

People who lived in Wantage Nursing Home and their relatives thought their health and care needs were effectively met. They were also positive about the standard of the care and nursing staff. Relatives told us; “Mostly the care is good and the longer serving carers are brilliant” and “There have been some acts of extreme kindness by carers which have been over and above the call of duty.” Another relative said care staff were “very good” and they “had a lot of time for them”.

People who received care and support, together with people responsible for them were involved with care planning. People indicated they were far more likely to achieve what they wanted from their care through informal conversations rather than formal reviews, although they confirmed these did take place.

We received feedback from GPs and NHS professionals involved with the service. They were positive about their interaction with the service and the quality of care and support they observed. They told us the staff followed their advice and recommendations and where there were any areas of concern, these had always been addressed promptly.

Interactions we observed between staff and people living in the home were polite, respectful and friendly. There was a very relaxed atmosphere throughout the home and while staff were busy, they were able to ‘chat’ informally to people in lounges and dining areas. At mealtimes, although very busy, care staff helped people at an easy pace and ensured they were comfortable by talking with them and checking.

People’s dignity was upheld. We observed staff were involved with people in an appropriate and positive way. Staff used people’s preferred names and appeared aware of the person, their families and interests. This helped create a relaxed and informal atmosphere within the home. One person told us how, in summer staff help them to sit out in the garden, which they were looking forward to when the weather improved.

Activity staff said they looked at people’s care plans to identify their life history, and any specific interests, people or events in their lives. They then used this information to inform activity planning including the one to one sessions that they undertook with individuals. People’s spiritual needs were addressed through contacts with caring and religious organisations within the community.

The registered manager confirmed advocacy services were available if people required them to support them to express their views. In most cases however, we were told people either self-advocated or their relatives did on their behalf.

Good

Is the service responsive?

Our findings

People told us that in most cases they felt their care was focussed on their individual needs. When there was a consistent staff team they told us they felt staff knew them as individuals. They confirmed they were able to vary their daily routine, for example what time they got up and had breakfast.

During our visit we heard staff offering people a range of choices over what they did, where they wanted to be and what they ate, for example. However, one person thought ability to choose alternatives at 'tea time' was limited by the availability of the chef. They said this meant decisions about what they wanted had to be made earlier and could not be changed at short notice. People had been given the choice as to where they ate, and we saw staff taking meals to those people who had chosen to eat in their rooms rather than the dining rooms.

People were aware of there being a complaints policy. One relative said they had written to 'head office' about the quality of the food and had received a reply; "Quite quickly". People said they would be more likely to raise any concerns they had informally with staff or the registered manager.

One relative told us they had not bothered to complain as they did not feel anything would be done about it and had a concern their relative's care might be affected. We saw no evidence this would be the case. Two other relatives said they found staff and the manager responsive to any concerns or issues, for example when things had gone missing from one person's room this had been satisfactorily resolved. Another relative told us that when their relative had problems with the consistency of the food, a soft diet had been provided which had proved helpful and effective.

The registered manager told us a record was kept of any relevant discussions with family contacts arising from telephone calls or visits. This enabled minor concerns to be dealt with promptly and any trends or patterns in concerns identified and acted upon.

People were generally appreciative of the activities staff. They said the programme was quite varied. There were details of the day's activities available on the day of our visit. One healthcare professional thought there could possibly be more exercise and one to one activities for those people who were confined to bed. Staff confirmed people were supported to maintain their religious observance if they chose to do so. People were encouraged and assisted to access the garden.

Care plans included assessments of people's needs prior to them moving into the home. They included details of the support people required including with their mobility, medicines and any specific health conditions. There were details of their medical history together with details of their preferences as to daily routines and care, including their end of life wishes.

We received mostly positive comments from healthcare professionals about the standard of care planning. Care plans included background history of the person concerned where it had been possible to get the details from the person or their families. One person thought life histories could be better; however they recognised it was not always easy to get the information from people or their relatives.

Care plans were reviewed monthly and we were told that was when any significant changes were recorded. Staff confirmed they had access to care records and demonstrated a good knowledge of individual people and their current needs. They were able to give details about how people's care needs had changed over time. This confirmed people's changing needs were being met.

Good

Is the service well-led?

Our findings

Relatives confirmed they had completed questionnaires and had also met informally with the registered manager to discuss their relative's care and provide feedback. There were regular meetings with relatives and we were told after the inspection one had been held in March which had been well-attended. People confirmed the registered manager had responded to any concerns they had raised. One said; "I don't see much of the manager except as I go in and out, but they always had time for me when I have asked to see her".

CQC were contacted by one relative with a concern. They said they had a meeting arranged with the registered manager and would contact us following that. When they did, they told us they were now very satisfied with the response and the matter had been closed.

Staff confirmed they had the opportunity to discuss any issues with their line manager or the registered manager formally or informally. We saw minutes of staff meetings held to discuss issues and share information. Staff told us they were aware of the provider's whistle-blowing policy. One said whistle blowing had been talked about on their induction and they would be happy to raise any concern with management and hoped they would respond positively. They said they felt the registered manager would try hard to resolve any concerns they had.

The service monitored activity and performance in order to identify areas where improvements could be made and to ensure the service was safe and effective for the people who lived there.

There were a series of regular audits carried out on specific areas of the home's operation. There were systems in place, for example, to monitor and record the administration of medicines and maintenance of equipment, including call bells and fire alarms. This helped ensure any safety or maintenance issues could be promptly identified and addressed.

We saw a copy of a detailed and comprehensive regional manager's monthly compliance visit against 12 'fundamental standards' carried out on the 23 February 2015. This report highlighted any areas where the need for improvements had been identified. We saw a copy of the Service Improvement Plan which then addressed the results, not only of those monthly audits but nine other monitoring activities carried out either by the home, Sanctuary Care, external bodies or individuals. For example, the home had worked with the local authority towards addressing concerns raised by them in their regular monitoring visits to Wantage Nursing Home. We saw copies of the action plan draw up to address these and how progress had been made and measured towards completing the necessary improvements.

The ethos and values of Sanctuary Care were included in staff induction and Sanctuary Care publications and training materials.

There was a system in place for the reporting and recording of incidents and accidents. The CQC had been appropriately informed of reportable incidents as required under the Health and Social Care Act 2008.