Sandown Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 17 November 2016 and was unannounced. Sandown Nursing Home provides accommodation and personal care for up to 39 adults, including people with dementia and physical disabilities, who require nursing care. There were 33 people living at the home when we visited.

There was a registered manager at the home. 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 always protected from the risk of infection. We found staff did not always follow best practice guidance, the infection control arrangements were not clear or robust and some equipment was shared between people.

Medicines and some risks to people were not always managed effectively. Some regular medicines were administered too close together and some risks were not assessed or safely managed. This included the risks from fluid thickening powder and pressure relieving mattresses were not all set appropriately for the person's weight.

A quality assurance process was in place, however, this had not identified the areas of concern relating to some medicines being administered too close together, regular audits of medicines management were not being completed and infection control concerns.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed although documentation had not always been completed to demonstrate this. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. At the end of their life, people received appropriate care to have a comfortable, dignified and pain free death.

There were enough staff to meet people's needs. Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and external health professionals were positive about the service people received. People were positive about meals and the support they received to ensure they had a nutritious diet.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We found one breach 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?

Requires Improvement

The service was not always safe.

People were not always protected from the risk of infection. Staff did not always follow best practice guidance and the infection control arrangements were not clear or robust.

Medicines and risks to people were not always managed effectively. Some regular medicines were administered too close together and some risks were not assessed or safely managed.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. People received the personal and nursing care they required and were supported to access other healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

The environment and equipment were suitable for people living at the home.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the care they required.

People were offered a range of activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance process was in place, however, this had not identified the areas of concern relating to some medicines being administered too close together, regular audits of medicines management were not being completed and infection control concerns.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the management team.

The service had an open and transparent culture.

Sandown 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 inspection took place on 15 and 17 November 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 10 people living at the home and nine visitors. We spoke with the registered manager, the business manager, two nurses, two trainee nurses and seven care staff. We also spoke with ancillary staff including the activities staff, administration staff, the chef and housekeeping staff. We looked at care plans and associated records for eight people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with six healthcare professionals who had regular contact with the home.

The home was last inspected in October 2014, when we did not identify any concerns.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of infection. We found staff did not always follow best practice guidance and the infection control arrangements were not clear or robust.

Facilities and systems in use for the management of laundry placed people at risk of infections. The laundry room contained a sluice, which some staff told us they used for emptying the disposable commode pots. This was contrary to guidance issued by the Department of Health, which recommends that sluices should not be located in laundries due to the risk of cross contamination. The laundry room did not contain a hand washing sink, so staff were not able to wash their hands after handling soiled linen or commode pots. They told us they used a room half-way down the corridor for this purpose where they also disposed of the commode pots. However, this posed a risk that bacteria could be transferred onto door handles or other surfaces on the way. The person operating the laundry was not wearing a protective apron and there were no disposable aprons available in the laundry; these had to be brought from elsewhere in the home, which might have deterred staff from wearing them when handling soiled linen.

A metal trolley with three open shelves was used to collect laundry from around the home and bring it to the laundry room. We saw the trolley arrive at the laundry room piled high with clothes; they were at risk of falling off the trolley and were laid on top of bags containing potentially infectious linen. The shelves of the trolley were dirty and were secured to the trolley using industrial tape. The tape was dirty and curling up at the edges, which created traps where bacteria could thrive.

The Department of Health guidance recommends the use of soluble red bags for processing soiled linen, which can be put straight into a mashing machine without opening. Staff told us they only used the red bags if the linen had come from a person with a known infection. In other cases, they used "green bags" that were not soluble and had to be opened in the laundry room before being placed into a washing machine. This was not in accordance with the guidance as the opening of the bags posed a further risk of cross contamination within the laundry room.

Some people were supported to re-position in bed using slide sheets. A slide sheet is a piece of equipment made of slippery material which is designed to assist staff to move people with a minimum amount of effort. There were not enough slide sheets to allow them to be used on an individual basis, which meant each slide sheet was used to support several people to move. They were not laundered after each use, so posed a risk of cross infection between people. The provider took immediate action to purchase additional slide sheets when we raised this area of concern with them.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. It requires providers to produce an 'Annual statement of infection control' to review any outbreaks of infection, the infection control policies, risk assessments, audits and staff training. This had not been completed as the infection control lead staff member was not aware of the requirement.

Whilst there were policies and risk assessments in place to manage a variety of infection risks within the home, such as clinical waste and needle stick injuries, these had not always led to clear procedures. For example, the laundry policy did not mention the use of the sluice. The infection control lead person told us it should not be used as a sluice, but staff were using it as such. Although there were cleaning schedules in place for deep cleaning vacant bedrooms, these were not accurate. They showed no deep cleaning had been completed since May 2016, but we saw a room that had recently been deep-cleaned. The cleaning records for daily cleaning of communal areas had only been signed once a month rather than each day as required. The absence of accurate records meant the provider was not able to confirm that all necessary cleaning had been completed.

The failure to provide care and treatment in a safe way by assessing, preventing and controlling the risk of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had an infection that was resistant to antibiotics. Staff were aware of the precautions they needed to take to prevent the spread of this infection and we saw they followed safe working practices when supporting the person.

Procedures to administer medicines had not ensured that people always received these safely or as prescribed. Some people were prescribed medicines which were required to be administered up to four times per day. This included medicines such as paracetamol which should be given at least four hours apart. We found some people had received these medicines with intervals of less than four hours between administrations. This placed people at risk of overdose and complications resulting from their medicines. We discussed this with the registered manager who took immediate action to introduce a new system to prevent this from occurring in the future. Regular audits of medicines management were not being completed by the home, although an external pharmacist had undertaken a medicines audit in January 2016. We saw that any actions this had identified had been completed. For example, staff were now recording the maximum and minimum daily temperatures for the medicines fridge. This meant staff would know medicines had been stored at the correct temperatures and were therefore safe to use.

There were appropriate arrangements in place for obtaining, recording, safe storage of medicines and the safe disposal of unused prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. We were unable to undertake a formal check of medicines stocks as nursing staff had not always recorded when fresh supplies had been commenced. Registered nurses told us they had received training in medicines management and administration at the home in addition to that completed during their nurse training. We observed nursing staff administering medicines to people in a patient manner, and informing people what the medicine was for. They did not hurry the medicines rounds and we found the Medicines Administration Records (MAR) were mostly well completed with only a few gaps.

There was a procedure in place for the covert administration of medicines although nobody was receiving their medicines in this way at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedure that would be used would protect people's legal rights. It would ensure that all relevant people, including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used 'as and when necessary' (prn) protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people.

Where individual risks to people were identified action was taken to reduce the risk. These included, for example, the risks to people of falls, choking, nutrition and skin damage. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. However, pressure relief mattresses were not all set appropriately, according to the person's weight. For example, one person told us their mattress was hard and uncomfortable. We found this mattress was set for a person almost twice their weight. The registered manager stated they had recently introduced a system whereby a nurse checked these. However, this had not ensured they were correct, placing people at risk of skin damage from equipment intended to prevent this. People were assisted to change position regularly to reduce the risk of pressure injury. Moving and handling assessments set out the way staff should support each person to move. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance.

Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. However, the risk to people individually and in communal areas from a fluid thickening powder had not been assessed. We saw tins of the powder located in bedrooms and communal areas within people's reach. The registered manager was aware of the risk this presented to people but had not ensured the risk was assessed or action taken to minimise the risk. The registered manager subsequently undertook risk assessments for the thickening powder. Other risk assessments, with specific actions to reduce the risk where possible, were relevant to the individual person and had been regularly reviewed.

People told us they felt safe. One person said, "I was worried about coming to a nursing home but since I have been here I am much happier". Another person told us "I feel safe. Nothing worries me really." A visitor told us "I have no worries, I know [my relative] is safe here". They and other visitors told us that when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relative was safe at Sandown Nursing Home.

The provider had appropriate policies in place to protect people from abuse. Staff had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. Staff were also aware of external organisations they could contact for support, including the local safeguarding authority. One staff member said, "If I had any safeguarding concerns, I would report them to the nurse or [the registered manager] or [one of the providers], then to CQC." Another staff member told us, "I would go to [the registered manager] first, or the office. I know I'd get a good response from either." The registered manager and the business manager took their safeguarding responsibilities seriously and worked closely with the local safeguarding authority to protect people from harm. For example, one person was at risk from a visitor and, after liaison with the relevant authorities, a plan was put in place to protect the person. There were notices around the home about the importance of staff awareness to signs of abuse and the process for reporting safeguarding matters.

Risk assessments were completed for all aspects of the environment and measures identified to reduce the likelihood of harm. For example, the temperature of hot water was regulated to prevent scalding and arrangements were in place to check that gas and electric systems were maintained in good condition. Equipment, such as hoists and lifts, were serviced regularly to help ensure they were in good working order and safe to use. Where remedial action was needed, this was completed promptly. For example, a review identified the need for more staff to be trained to operate the passenger lift manually in the event of an electrical failure and this had been done.

There were plans in place to deal with foreseeable emergencies. Weekly checks of the fire safety equipment were conducted, together with regular fire drills. Staff knew what action to take in the event of a fire or other emergency. They had been trained to deliver first aid and a defibrillator had recently been installed at the home, which staff were being trained to use. Personal evacuation plans had been developed and included details of the support people would need if they had to be evacuated from the building in an emergency. Nurses had access to an 'emergency folder'. This contained relevant information and procedures for managing a variety of potential emergency situations such as severe weather, loss of power to the home or a missing person.

People told us there were enough staff to meet people's needs. One person said, "If I press my bell, [staff] usually come quite quickly." A family member told us, "If you ring the [call bell] staff are here very quickly." Other people and visitors confirmed that staff responded promptly when call bells were used and they felt there were usually enough staff available. By 11:00am care staff had completed their morning care routines and were seen to have time to spend with people and update care records. Staff responded promptly to call bells. During a busy time in the morning we saw call bells were answered promptly.

Staff told us their workload was "achievable" and we saw they responded promptly and compassionately to people's requests for support. The business manager told us staffing levels were discussed with the registered manager and were based on the needs of people using the service. When setting the staffing rotas, they took account of the skill mix to help make sure staff with the necessary qualifications and experience were available throughout the day. The business manager had recently completed a 'time and motion' study to better understand the staffing requirements. This had identified the need to recruit an additional care staff member, which was being progressed. Absence and sickness were usually covered by permanent staff working additional hours, which meant people were cared for by staff who knew them and understood their needs.

There was a suitable and robust recruitment procedure in place to help ensure staff were suitable for their role. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions. Files for recently recruited staff showed all necessary checks had been completed.

Good

Is the service effective?

Our findings

Some people living at Sandown Nursing Home had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. The Mental Capacity Act, 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People told us they received the personal care they required in a way that met their preferences. Care staff told us how they offered choices and sought consent before providing care. One said "If they said no, we don't do it but try later and tell the nurse. We would record this and try a different staff member." Another staff member told us "If people [decline care], I would try to encourage them. One person often refuses personal care, but if you approach them in the right way by saying 'I really need to change you' then they agree and afterwards appreciate it." During the handover between the morning and afternoon staff we heard staff explaining how they had encouraged a person to have a wash and that they had agreed to this.

Care plans contained information about the decisions people could make for themselves although this information was not always consistent within the care plan or related to the current ability of the person. Where people were unable to make decisions about their health or personal care best interest decisions had not always been recorded. For example, one person's care plan stated they lacked capacity to make a decision about their medical needs. It noted 'a moderate impairment due to dementia' and said they were 'unable to retain or weigh up information'. Whilst staff were clearly meeting the person's medical needs, no best interests had been documented to show who had been consulted or why it was in the person's best interests to receive the care and treatment being delivered. The 'consent to care' forms (for medicines, personal care, continence, mobility, and nutrition) had been signed by the person's relative, who only had a Lasting Power of Attorney for finance, not care and welfare. The registered manager stated they would review the relevant documentation and ensure best interest assessments were formally recorded. Care plans contained information as to who had the legal right to make other decisions on behalf of the person. When in place, copies of the legal documents confirming this were held.

People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met. One person was independently mobile and they told us they were able to leave the home without restriction.

People received the personal and nursing care they required. One person said "The staff are very good; I get all the help I need." A visitor told us they were happy with the way their relative's personal care needs were met. The relative confirmed that health professionals were contacted when required. This was also the view of all people and relatives we spoke with. Staff recorded the personal care they provided including if people had declined care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. The registered manager stated nursing staff reviewed records of care to monitor that people were receiving the care they required. The registered manager told us they considered the needs of existing people when deciding if they would admit new people. They told us "At present we have an empty bed, but I have refused referrals, following assessment, as their care needs were too high". This meant staff should continue to be able to meet people's needs.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. Care staff told us they had been provided with information about new people prior to them being admitted. They said this helped them to understand the person's needs and how they should be met. People were seen regularly by doctors, opticians and chiropodists as required. One person said, "[Staff] took me to St Marys [hospital] a few weeks ago to see the neurologist and they increased my medicines." Sandown Nursing Home had equipment suited to the needs of people living there. The registered manager was aware of how to obtain specialist equipment for people who required this due to their body shape or size. They said they would only admit people for whom all necessary equipment was available. One visiting health care professional said they had raised concerns about staff not undertaking physical exercises with a person and the registered manager had acted to ensure these were now undertaken. We spoke with five other visiting healthcare professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People's nutrition and hydration needs were met by staff who had time to support them to eat when necessary. One person told us "The food is very good and there is always a choice of meals". A visitor said, "I'm often here at lunch time and the food always looks and smells nice. I have had a dinner here and the food is good". Records showed people were provided with food when they wanted it. The chef showed us a list where staff recorded sandwiches provided to people during the evening or at night. Staff told us they could provide people with food at any time this was requested or required. A person told us that, although they had never asked, they felt sure they could get food during the night as "The staff get me drinks if I ask them".

People received the appropriate amount of support and encouragement to eat and drink. Staff encouraged people to go to the dining room at lunch time where they were given a choice as to where and who they would like to sit with. This meant people were able to enjoy a social occasion as well as having their nutritional needs met. Other people chose to remain in the lounge and were seen to receive support as required. Staff were attentive to people and whilst promoting independence, noted when people required support. Where people required support this was provided patiently, giving people time to finish one mouthful before they were offered more.

One person was receiving their nutritional needs via a tube directly into their stomach as they had been assessed by the Speech and language Therapists (SaLT) as not being able to safely swallow. Care plans contained information from the dietician as to how their nutritional needs should be met, including the amount of fluid they should receive each day. Records showed they were receiving the correct amount of fluids and nutritional prescription.

Staff, including kitchen staff, were aware of the specific dietary needs of individual people. For example, kitchen staff were aware of which people required their meals in a softer format or had dietary restrictions such as due to a medical condition. A staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Meals, including those which had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink. Records of the amount people had eaten or drunk were kept. These showed people were provided with regular drinks and meals. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place.

People's needs were met by staff who were skilled and suitably trained. A family member said of the staff, "They seem to know what they're doing. They do the best they can for us." Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This was based on a range of computer-based modules, supplemented by face-to-face training and practical training, including supporting people to move safely. They then worked alongside more experienced staff until they were considered confident and competent enough to work unsupervised. Arrangements were in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care.

All staff were up to date with the provider's mandatory training. Nurses were supported to undertake study to support the needs of their registration and training to meet the specific needs of people living at the home. For example, they had attended training in end of life care for people living with dementia, syringe drivers, catheter care and pressure injury care. Staff demonstrated an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques; and they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance.

People were cared for by staff who were appropriately supported in their role. All staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the management on a day to day basis. A staff member told us, "At my last appraisal, I mentioned first aid training as I felt I needed it and it was delivered."

The environment was appropriate for the care of people living at Sandown Nursing Home. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. This would help people to settle in and feel at home. There was a spacious and bright communal lounge with several separate areas and a bight dining room. People could access the garden which was level and suitable for those with limited mobility. There was a choice of several bathrooms or shower rooms, suitably equipped to support people with high care needs and located close to people's bedrooms.

Good

Is the service caring?

Our findings

People were consistently positive about the way staff treated them, saying that all the staff were kind and caring. One person said "Staff are fine with me and always close the door when seeing to me." When asked if they thought the staff were caring, another person said, "They are all very good and polite." Relatives also felt staff were caring. One said "They always treat her well." Another visitor said "[Relatives name] always had cats at home, she loves them and we have been able to bring in our pet cat to visit which she loves." We saw the cat lying peacefully on the person's knees and the evident enjoyment the person received from this visit. Another visitor said "The staff are friendly, we have a laugh and a joke with them".

We observed staff over the course of our inspection and found they were caring and kind. Staff spoke to people in a respectful but friendly manner and people responded in a similar manner. Staff had a good awareness of people's needs and there was a great deal of warmth evident between staff and people. Staff responded to people in a caring way that also protected their dignity. For example, a privacy blanket was put over a person's lap when staff used moving and handling equipment in a communal area. We observed staff supporting people with their meals in ways that were kind and patient.

Staff protected people's privacy and dignity at all times. People confirmed their privacy was maintained by care staff when they were receiving personal care. One person said staff always "Close the curtain and door". A visitor said "[Staff] always close the curtains and door for personal care and [ask me to leave the room] while they are seeing to [my relative]." From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said "We make sure people are covered and promote independence for them to do as much as they can". A visiting healthcare professional said "Privacy and dignity is okay. [Staff] ask the patients for permission all the time and ask me to go outside if they need personal care." Staff knocked and sought permission before entering people's rooms. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed. Care staff told us which people preferred care from staff of a specific gender. They told us this was always met. One staff member said "If someone says 'I don't want you', that's fine; I go away and get someone else [to support the person with personal care]."

People were supported without restricting their independence. One person told us how staff enabled them to continue to do things for themselves. They said "As long as I can do it they let me, like making my own bed and having a shower". The registered manager told us they had previously contacted the occupational therapist for information and equipment to promote a person's independence when eating. One person liked to smoke cigarettes. Staff supported them with this and told us they took the person outside whenever they requested this. Another person had been supported to move to an E-cigarette and we saw them using this. People were provided with coloured drinking glasses and place mats with contrasting colours to

crockery. This would help people with vision needs or living with dementia to more clearly identify and use these, thereby promoting their independence.

Staff knew about people and what was important to them so that care was individual and centred on each person. Sandown Nursing Home allocated a named member of staff as a key worker for each person. The registered manager said the role of the keyworker was to "Spend extra time with the person, advocate on their behalf and ensure the person has any items they require including toiletries and treats". Staff told us that at Christmas the provider gave keyworkers money with which to purchase gifts for their key client via a 'secret Santa'. Staff told us they shopped for these in their own time and it was evident consideration was given as to what each person would like to receive.

Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. Each week a Christian minister visited the home and the registered manager was aware of how to contact other religious leaders if required.

People were supported to express their views and were involved in making decisions about their care, treatment and support. Staff described how they involved people in choices. One said "We ask them, or we pick some bits from their wardrobe and show them". Staff were skilled at communicating with people. Many people living at Sandown Nursing Home had some level of communication difficulty. Care plans contained a section relating to communication and gave staff guidance as to how they should communicate with people. For example, one person was unable to communicate verbally and staff had produced some pictures to help them make choices. Another person did not have English as their first language. Pictures with some words in their first language were available to aid communication. Care plans included information about aspects of life where the person was able to make choice. For example, one care plan stated: "Promote choices. Able to choose food, drinks and clothes, although unable to retain information." People who wanted to leave their bedrooms were able to use the communal rooms as the home had suitable seating for everyone's needs. One person said they liked to sit in a particular place in the lounge and we saw they were sitting in that place on both days of the inspection.

People, and when appropriate relatives, were involved in care planning and reviews of care. One relative told us they had been involved in a review of the care plan. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said, "[Staff] tell us of any changes; I'm in most days and the staff always tell me how [my relative] has been." Another visitor said of the staff, "They [staff] call me if there is anything I need to know". Where appropriate, relatives were supported to continue to provide some care for their loved one. We saw a visitor supporting a person with their lunch showing that they were enabled to maintain their relationship and feel that they were involved in the care of their relative.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. A thank you letter had been received which stated staff had 'gone the extra mile' and thanked staff for having time to talk with the relatives and for the donation to charity the home had sent in the person's name. The business manager said flowers would be sent or a donation to the chosen charity if relatives had stated no flowers. Records relating to the care a person had recently received at the end of their life showed staff had acted to support the person as they wished. Staff had administered additional pain relief and symptom management medicine when this was required. Nursing staff had also contacted the person's GP to obtain additional pain relief medicine in a suitable format. Nursing staff had attended training to enable them to better manager symptoms people may have at the end of their life. They were aware of how to obtain and administer symptom management medicines should these be required. The registered manager

was aware of who they could contact for additional support if required. Information about people's preferences for their end of life care were included within care files.

Good

Is the service responsive?

Our findings

Nursing and care staff were able to describe the care and support required by individual people. For example, they were able to describe the support people required to meet nutritional needs and how people should be supported to move or reposition. Care plans were well organised and provided comprehensive individualised information, which corresponded to the care people were receiving. Care plans were reviewed regularly in relation to all key areas, such as continence, cognition, moving and handling, medicines and nutrition. Staff were kept up to date about people's needs and any changes to these through a formal handover meeting at the start of each shift. The handover between morning and afternoon staff included all information staff needed to be aware of when providing care. Morning care staff handed over information to the nurse in charge, including all aspects of care they had provided and whether people had received adequate food and drinks. Where necessary, the nurse asked questions to clarify and noted any action required, such as to check whether a person may require 'as needed' medicine for constipation.

Care plans contained information as to how people's known medical needs should be met including indicators that the person may be unwell or at risk of deterioration. For example, one person had epilepsy following a stroke. Their care plan included information as to the indicators that may show they were about to have a seizure. Another person had diabetes and required insulin several times each day. Their care plan detailed the management of their insulin; however, it did not specify the action staff should take if blood sugar tests were overly high or low. The registered manager arranged to add this information to the care plan immediately. Care plans for people with wounds were detailed and included evidence that these were managed by a whole person approach with consideration to nutrition and repositioning as well as assessment and redressing of wounds.

Staff responded appropriately when people's health needs changed. For example, staff had identified that one person's swallowing capacity had improved. They had consulted speech and language Therapist (SaLT) for advice and updated the person's care plan to reflect that they no longer needed a pureed diet and could manage a soft diet. For another person staff had identified deterioration in the person's ability to swallow and had requested an assessment. This had identified the need for the person to have their drinks thickened and we saw them receiving their drinks to the correct consistency. A visitor told us staff identified when their relative was unwell and would call the doctor. They gave an example of when staff had requested the GP and antibiotics had been proscribed. This showed staff were aware when people needed assessment and treatment from external medical professionals. A person told us "If you don't look right they offer to get the doctor in". Action was also taken when people experienced unplanned weight loss. We saw a person's GP and a dietician had been consulted. The person liked milky drinks and so was provided with these made with fortified milk. Records showed the person had subsequently gained weight.

Staff had information as to how they should respond to medical emergencies. A care staff member told us they had requested, and attended, additional first aid training. They had felt this was necessary as they often worked in the home during the evening when there was only one trained nurse and felt they needed the skills to provide support in an emergency. Nursing and care staff were aware where emergency equipment, including suction equipment and a defibrillator, were located and there were systems in place to check

these were working correctly.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded. Forms showed that, where necessary, external medical advice was sought and action was taken to monitor the person for any signs of deterioration. Appropriate action was taken to reduce the risk of repeat incidents, such as the use of alert equipment, to notify staff that people at risk of falls were moving around their bedrooms. When people required to be transferred to other care settings, such as hospital, the registered manager stated that a member of staff would always accompany the person. This meant the person was supported and individual information which would be helpful to others who may be required to provide care could be passed on.

People were offered a range of activities suited to their individual needs and interests. One person said "I like the music and they do some crafts and my nails". People received care and support from staff who knew and understood their history, likes, preferences and needs. Care plans included information about people's social history. Discussions during the handover between the morning and afternoon staff showed this information was known by care staff. One care staff member said "Some people have been with us a while and we've got to know their likes and dislikes. We try to use the radio now, rather than the TV, and choose more relaxing stations that they prefer." An activities coordinator was employed. Following admission, they completed a life history document with the person or their relatives. This included information about activities people may like to take part in.

We saw the activities coordinator arranged group and individual activities to suit the needs and wishes of people living at the home. They told us they were flexible in the activities they provided depending on people's health and abilities. The activities coordinator was aware of people's preferences; for example, they told us how one person enjoyed the music activities but not the craft ones. We saw people enjoyed the activities and interactions from the activities staff member. They interacted individually with people demonstrating a good knowledge of people and their needs. The activities coordinator told us they had a budget for equipment which could also be used to pay external entertainers to perform at the home. The activities co-ordinator was working with a charity who were able to provide volunteers to undertake individual activities with people. One person had received a service and others had been referred and were waiting for a suitable volunteer to be allocated.

The provider sought feedback from people, relatives and external professionals through the use of questionnaire surveys. Responses showed a high level of satisfaction with the service provided. Where issues were identified, these were investigated and used to improve the service. For example, one response highlighted the need for staff to be more discreet when chatting in front of people and we saw the business manager had reminded every staff member of the need for discretion.

People knew how to complain or make comments about the service and the complaints procedure was displayed in the entrance hall. Most relatives and people told us they had not had reason to complain but would contact a staff member if needed. One person told us, "I mentioned about staff not clearing away the dishes after meals. [The business manager] said they would look into it and I think staff have been in and out more since then."

Records showed that complaints were used to develop and improve the service. For example, a concern had been raised about the lack of progress a person was making after having had a stroke. Action was taken and the person was given additional support from staff to undertake their prescribed exercises. The complainant also received a comprehensive written response explaining the action that had been taken.

Requires Improvement

Is the service well-led?

Our findings

People enjoyed living at Sandown Nursing Home and told us the service was well-led. A person said "You could not come to a better place, all the staff are here to look out for you". Another person said "There very good here". A family member described the service as "beautifully run". A person told us the provider visited them most weeks and asked if they were happy with everything. A relative of a person also told us that the provider made a point of talking to them. Many people and visitors were able to name the provider, business manager and registered manager, showing that the management team made sure they were available to people and visitors.

There was a quality assurance process in place. However, this had not identified the areas of concern relating to some medicines being administered too close together, regular audits of medicines management were not being completed and infection control concerns. An audit of the laundry procedures had been conducted by the laundry worker and had not been subject of any oversight by management. It had identified the lack of disposable aprons and a pedal-operated waste bin in the laundry, but these deficiencies had not been addressed. It had not identified the risks posed by the sluice, the use of inappropriate bags for soiled linen or the cleanliness issues with the laundry trolley. The infection control lead stated they would address these issues and ensure that future audits were overseen by a manager. The overall quality assurance process auditing the service against the five key questions we ask about services. Where changes were needed, specific actions were developed and implemented. For example, the audit identified that clearer notices were needed about how to raise a complaint and these had been put in place. It also identified the need to improve communication within the staff team which had been addressed by introducing a new form to enable staff to highlight clinical or other issues that needed to be shared with staff. These now formed part of the handover process at the start of each shift and helped staff keep up to date with people's needs.

As part of the appraisal process, staff were encouraged to identify ways to improve the service. For example, one staff member had suggested a change in the length of time they worked in each area of the home, so they did not lose touch with the needs of people living in other areas. The provider had adopted this suggestion and staff told us it had helped them provide a better service for people. Another staff member had highlighted shortages in the housekeeping team, so the provider had employed an additional staff member to provide more resilience.

There was an open and transparent culture at the home. One person told us, "There's no restriction on visiting. They even let the dogs in to see me; they see it as their second home." Staff told us visitors could stay as long as they wished. Records showed that notifications about significant events were reported to CQC as required. There was a duty of candour policy in place which required staff to act in an open way when people came to harm and we saw this was followed appropriately.

There was a clear management structure in place consisting of the provider, who took an active role in the running of the home, a business manager, a registered manager and a deputy manager. Each member of the management team had specified responsibilities, which allowed the provider the time and space they

needed to take an overview of the service and monitor its performance. A duty manager system was also in place to enable staff to seek support and advice out of hours.

Staff understood their roles and responsibilities and spoke positively about the support they received from management. For example, a staff member told us, "There's good back up from management. The owner comes weekly and will raise questions about how staff are doing. We asked for a new wet room; they provided it and came to ask how we were getting on with it."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not provided care and treatment in a safe way by ensuring the assessment, prevention and control of the risk of infection. Regulation 12 (2)(h)