Review of compliance

Sanctuary Care Limited Wantage Nursing Home	
Region:	South East
Location address:	Garston Lane Wantage Oxfordshire OX12 7AR
Type of service:	Care home service with nursing
Date of Publication:	January 2012
Overview of the service:	Wantage Nursing Home is a care home with nursing which offers care for up to 50 people. The home offers a service to older people and people with physical disabilities.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Wantage Nursing Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 December 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us that it was a good place to live. Some people described it as an excellent and a perfect place to live. People told us that they were very comfortable and well looked after.

What we found about the standards we reviewed and how well Wantage Nursing Home was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced. Daily records did not always cross reference with the care plan records to show what actions had been taken.

Overall we found that Wantage Nursing Home was meeting this essential standard, but to maintain this we have suggested some improvements are made.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The home was clear about how to respond appropriately to safeguarding issues. Staff had been trained and knew how to protect the people in their care.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The home had and infection control policy based on the 'Code of Practice.' Staff had received training in infection control. The home made sure that staff understood and followed all relevant infection control procedures.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The home regularly reviewed staffing numbers and adjusted them to make sure that peoples' needs were met. Training supported staff to develop the necessary skills needed to meet the needs of people living in the home.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The home regularly reviewed the quality of the standard of care they were offering to the people who lived in the home. They responded to concerns and improved any areas that were identified as needing attention.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that it was a good place to live. Some people described it as an excellent and a perfect place to live. They told us that they knew what was in their care plans and agreed with them. People said that they did not think there was anything that the home could do better. People told us that they were very comfortable and well looked after. They said that they chose as much for themselves as possible and were always treated with respect.

Family members told us that their relatives seemed very happy in the home. They said that their relatives health and well being had improved since they became resident. Family members told us that staff respected peoples' dignity and privacy and offered help only when it was needed. They told us that they were very happy with the standard of care offered to their relatives. One family member described the care in the home as 'magnificent'. Family members said that people chose things for themselves and had a good quality of life.

Other evidence
The home was divided into two units, ground floor and first floor. There were 20 people living on the ground floor and 30 people living on the first floor. Where people lived was determined by their assessed needs. We observed the care in both units during the course of the inspection and observed a meal period on both floors. During the mealtimes, staff were seen to be interacting sensitively and respectfully. For example, they were telling people what they were doing and asking permission to put on their aprons and cut their food. People were given specialist utensils if appropriate. For

example, plate guards and special cutlery. People received meals in the correct form, for example chopped, mashed or pureed, as described in their plan of care. Pureed food was presented attractively in food groups and staff explained to people what they were eating. People had their choice of food, one person was offered three alternatives as they were not eating what they had been given. Drinks were given midmorning and at lunchtime. Fluid charts were kept for people, if required. Those reviewed were fully completed and up-to-date.

We looked at peoples' records which included their plans of care. The home manager or one of the unit managers had carried out pre-assessments, before admission. The plans of care were developed from these documents. The plans of care seen, included all the relevant information to enable staff to appropriately care for people. For example, a pain management plan, wound management, night routine and diabetes management. The daily record was detailed and up to date but did not always cross reference with the care plan records. For example, one person had been seen by the falls service who recommended new and better fitting footwear. These had been purchased but it was not clearly recorded that the recommended action had been taken. One person who had lost a large amount of weight over a two year period had food and fluid charts but there was no record of a referral to a dietician. We were told that a referral had taken place and that the advice given had been followed. The persons weight records showed that their weight had stabilised but it was not clear what action had been taken and when.

The care plan approval sheet was not always signed by the individual or their next of kin. Families and people who lived in the home told us that they were involved in developing their plans of care. The named nurse completed the plans of care and reviewed them monthly. The deputy manager or manager checked a sample of plans of care once a month. There were two handovers a day where any short term changes were made and verbally passed to the next staff team. On the day of the inspection there was an incident where the nurse had not been instructed by the previous shift how to complete a dressing and it was not written down. We were told that this was unusual.

Plans of care included any risk assessments that were necessary for individuals. These included risk assessments for falls, personal safety, nutrition assessments and monthly or weekly weight monitoring as the assessment required, moving and handling, skin integrity and fire. The home minimised the risks as far as possible and followed any specialist advice given. For example, they worked closely with the Oxford falls service, who visit the home regularly to give advice on minimising the risk of falls for the individual and the home.

There were records of other professionals' visits from the general practitioner, community psychiatric nurse, opticians and care managers. There was evidence that people chose the quantity and type of painkiller they wanted to take, if appropriate to their assessed needs. The GPs visited the home twice a week and whenever people needed to see them. Local people kept their own GPs, others were allocated to one of the two surgeries that the home used. People told us that they could see a doctor whenever they wanted to. We observed people discussing whether they wanted to see the GP. The manager told us that the home had a very good relationship with the surgeries and it was usually the same doctors who visited people, to aid continuity of health care.

The home had reported 24 deaths since October 2010. The manager told us that this was not unusually high. The home offered end of life care and care to some quite 'poorly' people transferred from hospitals. None of the deaths had been referred to a coroner and there had been no concerns from other professionals in relation to the number of deaths.

Our judgement
The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced. Daily records did not always cross reference with the care plan records to show what actions had been taken.

Overall we found that Wantage Nursing Home was meeting this essential standard, but to maintain this we have suggested some improvements are made.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us that they were comfortable with all the staff and felt very safe in the home. Relatives of people who lived in the home told us that they visited frequently and were very confident that their relatives were safe. People who lived in the home told us that they had never seen anything untoward or anything that caused them concern.

Other evidence
There have been no reported safeguarding issues since October 2010. We saw that Deprivation of Liberty referrals were made appropriately by the home. The nurses had attended Mental Capacity Act training and assessed peoples' mental capacity to identify when a referral to the Local Authority needed to be made. The home did not use physical restraints and all relevant risk assessments were in place, including those for behaviour that may cause harm or distress to people who lived in the home. The behaviour plans were not detailed. The use of bed rails was risk assessed but the consent form was not signed by the individual or next of kin.

Training records showed, and staff confirmed that they had received safeguarding training. They described how they would approach an outside agency if the organisation did not respond effectively to their reported concerns. Staff spoken with were confident that the management of the home would take any safeguarding concern very seriously and take the appropriate action to protect the people in their care.

Our judgement
The home was clear about how to respond appropriately to safeguarding issues. Staff

had been trained and knew how to protect the people in their care.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People told us that the home was always clean and tidy.

Other evidence
The home had a copy of the Code of Practice on the prevention and control of infections and related guidance and had developed a policy and procedure based on this. The home had hand washing facilities and staff were seen using them. They had an infection control designated nurse who was responsible for ensuring everyone was properly trained and adhering to the infection control policy. The organisation had a clinical manager who audited all infections and infection control procedures.

The home was clean throughout. The plans of care for people with infections detailed how staff cared for them, to minimise the risk of cross infection. The laundry used a coloured bag system. The red bags, used for infected laundry, were dissolvable and were put straight into the washing machine. Orange bags were used for laundry that was potentially hazardous. The home had an infected waste contractor who collected and replaced the yellow waste bins. The home had hand washing facilities and staff were seen using them. Staff used different coloured aprons for different tasks. For example, food handling and personal care.

The training records showed and staff confirmed that they had received infection control training.

Our judgement
The home had and infection control policy based on the 'Code of Practice.' Staff had received training in infection control. The home made sure that staff understood and

followed all relevant infection control procedures.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us that there were always staff around and they could get up and go to bed whenever they want to. One person said the staff usually answered the bells quickly but they sometimes had to wait a bit too long. Other people said that they always got attention when they wanted it. People told us that staff were always very respectful and protected their privacy and dignity.

Other evidence
The home had a total of 62 staff. The minimum staffing was four staff on the ground floor and six staff on the first floor, during day time hours. At night there were two staff on the ground floor and two on the first floor. The basic staffing level was one staff member to five people who lived in the home. The manager adjusted this depending on the assessed needs of the people resident in the home. The manager increased staffing levels as necessary and had recently increased the staffing on the ground floor to five staff in the mornings. Some staff told us that there were not enough staff on the ground floor when there were four staff on duty. They said that this sometimes resulted in people staying in bed until mid morning. People who lived in the home and their families did not raise this as an issue. The manager had been told of the concerns, by staff and now tried to ensure there were five staff on duty. She was also reviewing shift management and organisation. The rotas seen for December 2011 showed that there were five staff allocated to the morning shift on the ground floor and a minimum of six on the first floor. The home had domestic staff to support the care staff with cooking and cleaning activities.

Staff embarked on qualification training after they had completed their probationary period of approximately four months. All staff had completed mandatory training and four people were completing the diploma in Health and social care. The organisation had its own learning academy to provide training, and advice on training, to managers and individual staff. Staff told us that they had good opportunities for training.

Our judgement
The home regularly reviewed staffing numbers and adjusted them to make sure that peoples' needs were met. Training supported staff to develop the necessary skills needed to meet the needs of people living in the home.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that they would tell staff if they were not doing what they should but they had never had any complaints. They said they were confident that if they had any problems staff would listen to them and put right what ever was wrong. People told us that staff always listened to them and did as they wanted them to. They listened to any suggestions and ideas they may have.

Other evidence
Care plans were reviewed monthly by nurses, the deputy manager and manager 'sample' them monthly. There were audit sheets in some of the plans of care.
The manager audited seven separate areas of the home monthly and the provider's representative completed monthly visits. The home changed medication providers after identifying issues as a result of the auditing process.

A quality assurance questionnaire was sent out annually, the last one was completed in June 2011. The main issue that was identified from the questionnaire was peoples' dissatisfaction with food. As a result a new chef was employed and people had much better quality and choice of food. Positive comments about the improved food were recorded in the monthly staff and three monthly 'resident' meetings. The manager discussed any issues with families and people who lived in the home on a daily basis but this was not recorded.

Complaints were appropriately recorded and responded to.

An accidents and incidents register was kept and audited to identify any overall trends or patterns. Individual accident and incident forms were kept in peoples' files.

Our judgement
The home regularly reviewed the quality of the standard of care they were offering to the people who lived in the home. They responded to concerns and improved any areas that were identified as needing attention.

Overall we found that Wantage Nursing Home was meeting this essential standard.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced. Daily records did not always cross reference with the care plan records to show what actions had been taken. Overall we found that Wantage Nursing Home was meeting this essential standard, but to maintain this we have suggested some improvements are made.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced. Daily records did not always cross reference with the care plan records to show what actions had been taken. Overall we found that Wantage Nursing Home was meeting this essential standard, but to maintain this we have suggested some improvements are made.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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