Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Wantage Nursing Home

Garston Lane, Wantage, OX12 7AR

Tel: 01235774320

Date of Inspection: 15 March 2013

Date of Publication: April 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Action needed
Staffing	✖ Action needed

Details about this location

Registered Provider	Sanctuary Care Limited
Overview of the service	Wantage Nursing Home is a care home with nursing that offers care for up to fifty people. Thirty of the beds are for people with dementia nursing care needs.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Wantage Nursing Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Staffing

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 March 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We previously inspected Wantage Nursing Home in October 2012 and found them non compliant with two outcomes. Since then the manager and deputy had both left the home. The new manager started work in December 2012 and the new deputy manager, in March 2013.

When we inspected this time to monitor the home's progress towards becoming compliant, we found that progress had been made in some areas but the provider was still non compliant with both outcomes.

Limited progress had been made in bringing care plans and related records up to an acceptable standard. The views and wishes of people in the home and their representatives were still not sufficiently integrated into care plans. The pace of improvement had been very slow despite ongoing monitoring by the provider. We saw from files that people's identified needs were not always recorded and if recorded, were not always effectively met. There was limited evidence of coordination between risk assessments identified needs and care plans. Some care records were not consistently completed.

Improvements had been made in the level of activities provided with the appointment of additional activities staff.

Feedback from people in the home and relatives remained negative about staffing levels, communication and morale. Staffing levels had improved with recent recruitment. However, the provider had yet to complete a dependency assessment to identify appropriate staffing levels. Staff morale and communication issues remained.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 30 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we inspected Wantage Nursing Home on 24th October 2012, we found the home non-compliant with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider was failing to protect people against risks associated with care that was inappropriate or unsafe. Care plans and risk assessments were poorly maintained not sufficiently detailed or personalised. We examined four care files. Two had been revised, in line with an action list prepared by the provider. The other two files were poorly maintained, lacked sufficient detail and required updating. We inspected the home again on 15th March 2013 to check on the progress made on achieving compliance.

A 'provider' audit of Wantage Nursing Home in August 2012, had identified 'major concerns'. There was a lack of involvement by people, in planning, reviewing and decision making around their care and incomplete care plans and risk assessments.

The provider undertook another audit visit in March 2013. The report identified that care plans fell short of satisfactory standards, and some were said to be "largely illegible". The audit noted some improvements but identified a training need for staff on care planning. No further improvements were noted with regard to decision making and mental capacity, since the previous audit. Ongoing concerns were noted regarding consent issues. Concerns were identified about other care records including inconsistent completion of food and fluid charts. Core training was also said to be "well overdue". The report did note improvements in the completion of risk assessments and activities provision. A 'Service Improvement Plan' was supplied at this inspection. The plan included action points on both areas of non-compliance and other core standards. However, it was undated and contained only one stated timescale. It identified the lead person for only one action point.

The January and February monthly monitoring reports by the regional manager also noted

limited activities and inaccurate/inadequate care plans. Both reports noted very slow progress on improving the care documents. A copy of a care plan matrix was supplied, which confirmed the limited progress made on their improvement. None appeared to have been completed. Varying degrees of progress were noted, with eight care plan said to be "almost complete" and seven said to be "progressing".

Recent weekly activity records showed that good progress had been made with the range and level of activities. The home now had 52 hours activity support from one full time and two part time activities staff. Activities were being provided throughout the week. For the last two weeks an activities diary had been produced. Some one to one support was now provided to individuals who spent significant time in their room or did not join in with group activities. However, the day of inspection was 'Red Nose Day' and nothing had been prepared in relation to this.

During the inspection we saw activities and care staff working with people, offering choices, encouraging participation and conversation. However, we saw that while some people received attention and interaction from staff, others did not. We carried out an observation for an hour, during which three people had no interaction at all. One person sat in her wheelchair throughout the observation and was not offered the opportunity to transfer to an armchair. We also saw instances where staff had failed to safeguard people's privacy/dignity, when bedroom doors were left open.

We examined a sample of care files and found key information was absent. For example, one person said their relative required thickened drinks to assist swallowing. However, there was no mention of this in the person's care plan. Another person had returned from hospital with pressure sores but no re-assessment of these or their other needs was completed until the third day after their return. Photographic and other records of the treatment progress for pressure sores were not comprehensive.

Care files were not in a systematic format. Some parts were not completed at all. It was not clear whether they were relevant to that individual. The various formats made it hard to obtain a clear overview of a person's needs. Some documents were missing or were undated. Signatures from the person supported or their representatives were not usually present. Therefore it was not possible to confirm their involvement or consent. The care plans we saw were hand written and were hard to read clearly, which meant that mistakes could be made.

We saw a bed-rails risk assessment on one file which was not signed by anyone to demonstrate any 'best interest' discussion. Bed-sides had been introduced for another person, following falls. However, the bed-sides risk assessment was not completed until 17 days later. Again there was no evidence of the 'best interest' process having been completed. A referral to the 'falls service' was made two days after the bed sides had been introduced. There was no evidence on file, of the outcome of the referral. In another file the falls risk assessment (undated), identified the person as 'very high risk'. They had had six falls, but the 'falls care plan' had not been completed. One person's nutritional risk assessment identified them as 'high risk' of malnutrition, requiring a referral for dietary advice. However, there was no evidence this had been done.

Care plans were very task focused and lacked individualisation. There was insufficient evidence of people's wishes and preferences. There was no evidence of systematic recording of regular checks on the welfare of those people with additional care needs, or who spent significant time alone in their room. Dietary and fluid charts lacked consistent entries and signatures. We saw that this was the case for one person who was diabetic.

This made it hard to reliably determine their nutritional or fluid intake.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were insufficient qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we inspected Wantage Nursing Home on 24th October 2012, we found the home non-compliant with Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough qualified, skilled and experienced staff to meet people's needs. The home had been carrying vacant posts for some time and agency nurse cover had been necessary. Significant numbers of people in the home required two to one staff support for parts of their care such as hoist transfers. People's nursing and personal care needs were not being met within an acceptable time. Staff sickness levels had risen and staff core training was in need of updating.

We inspected the home again on 15th March 2013 to check on the progress made towards achieving compliance. The provider had not carried out a dependency assessment to identify the current levels of need. However, 13 of the 25 people in the dementia unit and 10 of the 17 people in the nursing unit were now said by management to require two to one support for hoisting. The manager and regional manager said basic care needs were being met but acknowledged that they needed to re-assess current dependency levels to establish the staffing levels required to meet the full range of care and support needs. The regional manager told us the plan was to increase staffing by one care staff per unit per shift, pending a full review using a dependency assessment tool and dependant on the number of residents in the home. Current staffing levels were four care staff and one nurse throughout the waking day in the dementia unit. The nursing unit had four care staff and one nurse in the morning and three care staff and one nurse for afternoons and evenings. At night the current staffing was three care staff and two nurses across the home.

Sickness levels had improved with no agency care staff used in the previous two weeks and only six hours of agency nurse cover used. A system of return to work interviews had also been instigated to monitor sickness absence.

The regional manager told us the departure of the previous manager and deputy manager and the gap until the current manager was appointed, had slowed down work on the

identified issues. However, since the last inspection significant numbers of new staff had been recruited. A new home manager, a deputy manager and two full time nurses had begun work in the home. Two more full time nurses were due to start in April. Five part time, three full time and six bank care staff had also started in the same period. Two further bank care staff had been recruited but were awaiting a start date. Two new part time activities assistants had also been recruited plus additional domestic and catering staff.

The manager had yet to establish a system for monitoring the call-bell response times as part of reviewing staffing level requirements and staff responses. This had been an issue raised by people in the home and relatives. However, the call system company were booked to come in later in March.

The manager said regular supervision meetings and performance appraisals had yet to be established to support ongoing staff development. Recent team meeting minutes referred to the need for developments in team-working, communication, leadership, staff training and morale. The provider had identified a need for additional staff training to bring people's core training up to date and improve the understanding and completion of care planning and related documentation.

During the inspection we noted several instances where staff failed to maintain people's dignity by leaving bedroom doors open inappropriately. Management told us bedroom doors were either open or closed by the preference of the individual occupants. Staff told us that doors were often left open to enable easier monitoring of wellbeing as there were too few staff on duty and some of the pager units were not working.

People we spoke with in the home told us there were not enough staff. One said staff were always being moved around and she found this confusing. She said she would like the same staff so they got to know her. None of the people we spoke with or their relatives had seen a care plan. Another relative told us staffing had been particularly bad at weekends. One person said that agency staff had been ill informed about people's basic care needs.

At one point we tried to locate staff to assist a person who required support. We were unable to find anyone within the unit to assist her for some minutes. Relatives and people in the home told us about various instances where the call bells had not been answered for between 20 and 40 minutes. A relative told us that a person who needed staff assistance to transfer them by hoist to use the toilet, had once waited over 20 minutes, and no one came. The relative had gone in search of staff and the only care staff they found was not trained to use the hoist. This had reportedly arisen because two senior carers had gone on a break at the same time. A person in the home told us staff sometimes ignored the call bell at the end of their shift leaving it to the next shift, which could mean a 20 minute wait. People told us that they could not get support to use the toilet at mealtimes or other busy times. People in the home reported frictions between the old and new staff and a lack of communication between care staff and nurses. We were told the night staff got some people up early, not necessarily by their choice and that others were put to bed early by the day staff.

Most of the staff we spoke with told us things were improving now the new manager had started. They said the level of activities had improved. One person said that morale was much improved. Staff acknowledged that some people were not assisted to get up and go to bed at the time they necessarily would prefer.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to ensure that each service user was protected against the risk of receiving care or treatment that was inappropriate or unsafe, by means of the carrying out of appropriate assessments of need and appropriate planning of the delivery of care and treatment. Regulation 9 (1) (a) and(b).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22.

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

This section is primarily information for the provider

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 30 April 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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