Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

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

Overall summary

The Wingfield is a care home with nursing service, registered to provide personal and nursing care for up to 89 older people. The Wingfield is part of Barchester Healthcare Homes Limited; a large provider organisation. The service is housed in two separate buildings a short walk from each other on a site that is also shared with a GP surgery and pharmacy. The smaller building; The Lodge, has accommodation over three floors for up to 32 people. The second building; Memory Lane, has accommodation on two floors for up to 57 people, and specialises in providing care to people living with dementia.

The main kitchen and laundry and the administration offices for the service were located in the Memory Lane building. As well as care and nursing staff, hostesses were also employed by the service. Their duties included providing food and drink to people, greeting and helping visitors and to set and clear tables for meals.

The first day of the inspection was unannounced and the visit took place over three days between17 and 19 August 2015.

The service had a registered manager who was responsible for the day to day running of the home. A

Summary of findings

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.

Some stairwells and sluice areas in home were not cleaned to a sufficient standard, and other preventative steps had not been taken in relation to infection control such as using separate hoist slings for each individual, and disposing of incontinence waste products appropriately. This meant the home did not always manage the risk of infection.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the rights of people who lack mental capacity to make decisions are protected in relation to consent or refusal of care or treatment. CQC is required by law to monitor the application of the MCA and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The service had systems in place to record whether people consented to their care and treatment at the home. However, the requirements set out in the Mental Capacity Act 2005 (MCA) were not always followed when people lacked the capacity to give consent to living and receiving care at the home.

People said they felt safe living at the home. Staff were aware of their safeguarding responsibilities and showed positive attitude to this, and also to whistleblowing. We found that the home's safeguarding systems were not operated as effectively as possible and have made a recommendation about this which can be seen in the full version of the report.

We found that sufficient numbers of staff were not deployed fully to meet people's needs for person centred care.

The Wingfield did not operate complaints systems as effectively as possible because not all complaints and their outcomes were recorded. We have made a recommendation about this which can be found in the full report.

Checks of records indicated that reporting and recording of incidents and accidents took place. The premises and equipment were usually safe and adapted to meet people's needs. Medicines were safely managed.

People were complimentary about the food provided at the home. One person said, "there's a good choice and food is excellent." People's health needs were monitored and they were assisted to access healthcare services as necessary.

Staff acted in a caring manner; we observed they were warm towards people and spoke with respect. People who use the service were helped to make decisions about how their care was provided, and suggestions about how the home was run. However some of these suggestions had not resulted in improvements to the care they received. We have made a recommendation about this which can be found in the full report.

People spoke positively about the staff. One family member said, "They take every care… It's just like coming to a family."

We observed that people were given choices and consulted about their care. People, those important to them and staff informed us they felt confident to raise issues or concerns.

Each person who uses the service had their own personalised care plan which promoted communication.

People were assisted to go out into the community and to participate in activities.The service had quality and safety assurance information gathering systems in place but these were not always fully effective.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

The service did not always maintain a clean environment which promoted infection control.

Sufficient staff were not deployed fully to meet people's needs.

Risk assessments were used by the staff.

Staff were able to demonstrate good understanding and attitude towards the prevention of abuse.

Medicines were managed so that people could receive them safely.

The service operated a safe system for recruitment.

Is the service effective?

Requires improvement

The service was not effective in some areas.

The service did not always follow the requirements of the Mental Capacity Act when people lacked the capacity to give consent to care and accommodation.

Staff received sufficient appraisal, supervision and team meetings to support them to carry out their work as effectively as possible.

Staff members said they felt sufficiently trained.

People had access to food and drink throughout the day and were provided with support to eat and drink where necessary.

The premises had been adapted to people's needs.

Is the service caring?

Good

The service was caring.

Staff members had built caring relationships with people.

Care was provided in a respectful manner which protected people's dignity and observed confidentiality.

People were encouraged to express their views and preferences.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The service had a system to act on complaints and comments but this was not always operated effectively.

The service systems in place to share information with other services however the transfer of information to community services required improvement.

Summary of findings

The service sought and acted on feedback and comments but this did not consistently result in improvements to care.

Care and support did not consistently meet people's individual preferences.

People and their families participated in decision making about the care provided.

People were supported to have activities and interests and access to the community.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

The service had quality and safety assurance information gathering systems in place but these were not consistently fully effective.

The service had systems in place for keeping up to date with and implementing best practice.

The service had made community links.

There was an open and inclusive culture in the home: staff, people who use the service and those important to them expressed confidence to raise concerns.

The Wingfield

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.

Two inspectors and one expert by experience carried out this inspection which took place from 17 to 19 August 2015. An expert by experience is a person who has personal experience of either using, or caring for someone who uses this type care of service. The first day of the inspection was unannounced. Before the inspection we reviewed the information we held about the service, liaised with the commissioning and safeguarding teams at the local authority and read previous inspection reports.

We observed the care provided to people who use the service to help us understand their experiences. We looked around the premises and observed care practices. We spoke with the registered manager and 18 other members of staff including: housekeeping, maintenance, care and nursing staff. In addition we spoke with activity staff and the chef. We also spoke with 12 people who use the service and 14 relatives.

We reviewed 15 care plans and their associated risk assessments and records. We analysed three staff recruitment files plus training and supervision records. We checked documents including minutes of meetings, menus, quality assurance audits, the home's 'action plan' and a 'resident of the day record'. We read some of the records made when one shift of staff 'handed over' to the following shift, and the daily records made by staff.

We also checked cleaning schedules, surveys, policies and procedures, medication records, activities recording, and staff rotas. We also reviewed records of concerns and complaints, incident and accident reporting and safeguarding referrals.

Requires improvement

Is the service safe?

Our findings

Care staff said they thought people were cared for safely and people told us they felt safe. The service had contingency and fire plans in place however, records showed the weekly fire alarm system check was carried out on 25 July 2015 but there was a gap of three weeks before the next test on 17 August 2015. We were informed by the registered manager this was due to the unusual circumstance of two key members of staff who completed the fire alarm testing being on annual leave at the same time.

Staff said that they had received training in infection control, and records confirmed this. Information supplied by the home's training manager indicated that 97 % of the home's staff had completed training relating to infection control. Staff said cleaning responsibilities were set out in the cleaning schedules. The home had a food hygiene rating at the highest level dated 20 February 2015. People's feedback to us was that their rooms and communal areas were kept clean and our observations confirmed this.

However, some areas of the home needed to be cleaned such as both buildings' back stairwell areas. When we asked about this we were informed that due to staff shortages these areas, not often used by people, had not been prioritised. One relative said a stairwell had been in a poor state of cleanliness for several months and the doors were so dirty they avoided touching them.

On 18 to 19 August 2015, we found that one of The Lodge's sluices was dirty and posed an infection risk. A clinical refuse bag available was not in place and a used incontinence pad and disposable gloves had been rolled up and left on top of the bedpan washer. A soiled toilet seat raiser had been left in the sink with along with other items. Urine bottles and flower vases were piled upon the drainer; there appeared to be a lack of suitable storage racks. The hand washing sink in the sluice on the ground floor of Memory Lane was unclean and contained lime scale deposits. Staff seemed unaware as to whose responsibility it was to clean the sluice areas. A member of the domestic staff said responsibility lay with care staff members and a nurse said the domestic staff were responsible.

An infection control audit had taken place in April 2015 which recorded that hoist slings were 'individual and appropriate'. However, we were informed by care and nursing staff that people did not have their own sling unless it was a "specialist sling". This was contrary to good infection control practice.

This was a breach of regulation 12 (1) (2) (h) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

The service used its 'dependency indicated care equation' form (DICE) to work out nursing and care staffing levels. We asked the manager whether the staffing levels generated by the DICE were sufficient. They said additional environmental factors, such as The Lodge having three floors, needed to be factored in.

On 17 August 2015, we observed lunch in the ground floor dining room of Memory Lane; there were not enough staff to meet people's needs in a timely manner. One person waited 50 minutes after the start of service before their main course was served. We asked a member of staff about how busy the staff had appeared during the lunch service. They replied that what we had observed was normal because there were insufficient staff and meals always took a long time as a consequence.

We asked 13 staff for their views on care and nursing staffing levels.10 staff said there were not always sufficient numbers of staff on duty to meet all people's needs. One staff member said the service was "normally short staffed." Another said the service needed a higher complement of care staff. Another said that care staffing levels were "unacceptable".

Staff explained there were two issues. The first was the care giving staff complement was too low. The second was that when care or nursing staff did not arrive for a shift, due to planned or unplanned reasons, cover was not always provided. They said this left shifts short of their full staff complement about 20 % of the time during the day. Staff from other parts of the home; housekeeping and catering expressed a similar view.

The registered manager said that agency staff were seldom used to cover staff absences. They said it was sometimes necessary to cover absences in one part of the home by redeploying staff from another part of the home if no-one was available to work an extra shift. We asked on how many days the home had been short of its full complement of care providing staff from 24 July to 24 August 2015 inclusive. The registered manager said this had occurred

Is the service safe?

for approximately 56 % of the time period. They added that for approximately 21% of the 32 days in question, the home had either 4 or 5 beds empty and that therefore the staff shortage would not be covered.

Care and nursing staff all said that people's physical and safety needs were met but, due to staffing issues, people's psychological and social needs were insufficiently met. One member of staff said, "We can get the physical needs done" but added, "the sitting down to keep up the rapport - time to give your all and make [people] feel special" was not equally well done. Staff told us they felt rushed.

We were informed this concern had been raised with the management team. A member of staff said when they had raised concerns about this with their senior; they were advised to manage their time better. They commented, "I wish they would come into the care home and work on the floor." We saw several examples of this including we noted that six people in an upstairs lounge of Memory Lane did not receive any staff contact for at least 30 minutes. During this time one person was verbally and physically intimidating to another person. We noted that a distressed and tearful person was sitting alone in a downstairs lounge of Memory Lane for over twenty minutes. On the 19 August 2015, we checked the form used to record staff presence/ activity in the lounge on the afternoon of 18 August 2015. This documented the room had been 'empty' from 2pm to 6pm and no staff activity had been recorded during these hours. On the afternoon of 19 August 2015, we noted the same person was sitting alone in the same lounge from 12:20pm onwards. Shortly afterwards a carer came to give this person some lunch and noted this in the lounge diary. The person ate their lunch independently. At 3:15pm we observed this person was still alone in the same lounge. At 3:30pm the person became distressed but there was no staff contact until 4pm when two carers came to transfer the person into a wheelchair and noted this in the lounge diary.

People and their relatives also said that the home seemed to be short of staff. One person said, "You can often ring the bell and then no answer." A relative said, "I feel she is safe 90% of the time as there are times when they need more staff." They said, "When they [staff] are doing personal care mornings, lunchtime, teatime and evenings you can wait a long while as there are no carers around."

People gave us several examples of the affect this had on their lives in the home. One person said they would prefer to go to bed at 9p.m. but had to wait until 11p.m. because they needed extra help. They said staff were in a hurry to leave because they were so busy. They added, "The night shift are always pushed for time- sometimes [they] don't have time to change my pad and there can be long waits for the call bell." This person's relatives said that more than once during the day they had waited over 15 minutes for a response to the call bell, and in the end had assisted the person to use the WC themselves.

Another person said more staff would mean they would be able to walk more, and go into the garden. They said that no one came to check them and they just sat and read or looked out of the window. Their relative said, "Staff want more time just to be able to stop and talk for a minute or two" and added "the promotional material [of the home] is very positive but they need more staff to implement."

These comments reflected those gathered in the last residents' survey undertaken by the service which recorded people had said, 'staff do not seem to have enough time to stop, talk and listen as often as the residents would like.'

We were informed that in The Lodge just over 50 % of people were unable to use their call bell to summon help. Even so, during the day we noted that the call bells sounded for much of the day; one relative commented on this saying, "It would drive me insane." Approximately 63 % of people we were informed, needed two carers to assist them with their care.

At night, three staff were rostered to be on duty in The Lodge. This meant two members of staff may be required to assist one person, and the third member of staff may be required on either the same or a different floor as their colleagues. This would inevitably leave at least one floor unattended for periods during the night. Therefore, those people who were unable to use their call bell to summon help and who were reliant on staff to be present to observe and anticipate their needs, may not have had a member of staff on their particular floor for periods during the night which may have impacted on their safety and well-being.

Our observations, in combination with relatives' and people's feedback, supported staff members' comments that sufficient numbers of care staff were not deployed to fully meet people's needs.

Our observations and analysis of records indicated that insufficient care staff were deployed which meant care was not always given in a timely way that promoted comfort

Is the service safe?

and wellbeing, and reasonably mitigated risks. The registered manager said they hoped the three new general assistant posts would provide flexible cover for planned and unplanned staff absences, but that these workers would not be additional to the current staff complement.

This was in breach of Regulation 18 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

The service had arrangements in place to protect people from abuse and avoidable harm. Staff had received training on safeguarding and showed good understanding and positive attitude towards this. They were clear on what to do if they suspected a person who used the service had either been harmed or was at risk of harm. Staff were aware of the safeguarding and whistle blowing policies and procedures in place.

We noted that not all necessary safeguarding alerts for incidents had been made. These included a fall which caused injury to the head and required hospital treatment, and allegations of one person being slapped and hit with an object. This meant the home's safeguarding systems were not used as effectively as possible. The need for improvements in safeguarding record keeping was included in the home's action plan.

We found that care plans for nutrition and hydration were in place and that when people needed their drinks to be thickened, or soft pureed food this was seen to be provided during the inspection.

However, some records did not clearly define the actions required to reduce the risk to the person. One person was assessed as being at risk of choking. Their food intake chart indicated that they sometimes ate sandwiches and biscuits although the care plan stated both 'pureed diet' and 'soft diet'. The person's care plan did not clearly reflect what foods they could have and what level of supervision was required, only saying that staff should 'monitor alertness.' A relative raised this issue about another person. They said, "[the person] normally has a soft diet… but then they will give her a sandwich with hard meat in – surely they should understand?"

We found some gaps in records of: what food and fluid people received, when they had been helped to change their position and when staff had carried out 'comfort and wellbeing' checks. Some checks were recorded on the wrong forms; others did not happen at the correct intervals. For example one person at high risk of falls, should, according to their risk assessment, have received half hourly checks but we found these were recorded at hourly intervals. These gaps in recording may have increased the risks to people's safety. The registered manager agreed that some safety recording checks for people at greater risk such as: risks of falling, skin breakdown and poor nutritional intake, needed to be improved.

Staff members told us they followed the guidance set out in personal care plans and risk assessments when giving care to people. Care plans included individual risk assessments relating to personal needs, such as nutrition and hydration, continence and tissue viability. We saw that the service took steps to reduce risks. For example people who were at risk of falls were protected by measures including: sensor mats, increased levels of observation, lower beds, hip protectors and bed rails. Appropriate equipment was in place for people at risk of developing pressure ulcers (sometimes called bed sores). We also saw that safe systems were in place when staff supported to move from one place to another.

People's health and safety were promoted by a safe, comfortable environment. However we found that three alarm cords in the WCs had been tied up so that if people fell on the floor they may not have been able to reach up the cord to summon help. One person said they had been waiting for their uncomfortable bed to be repaired for several days. They said they were informed the delay was because maintenance staff were on leave. The registered manager was aware of this issue and we were informed the bed was fixed on 20 August 2015.

During the inspection, the head housekeeper was undertaking shifts in the laundry due to staff shortages caused by sickness and annual leave. Some domestic staff expressed the view that there were not enough cleaners. The head housekeeper said housekeeping staff "could be stretched" but that this did not compromise people living in the home. The registered manager said that the housekeeping team was not up to full strength due to sickness, and that recruitment was on-going including to three new 'general assistant' posts. This new role was intended to be used to flexibly plug gaps in staffing throughout the home including housekeeping, laundry and care work.

During the recruitment process the service obtained information to make judgements about the character,

Requires improvement

Is the service safe?

qualifications, skills and experience of its staff. The recruitment processes took steps to obtain proof of identity and qualifications of prospective employees. Disclosure and barring checks had taken place. The Disclosure and Barring Service helps employers make safer recruitment decisions by providing information about a person's criminal record and whether they were previously barred from working with adults. Disciplinary procedures were in place and used as necessary.

The service had an accident and incident reporting system in place. Medicines were managed properly and safely.

Staff kept daily care records and communicated any changes in people's needs, or concerns about care provision to each other. This was done for example, using daily 'handover' meetings where information was shared and recorded between staff. This meant that people's well-being and safety were promoted because staff members were usually quickly aware of any issues or changes in relation to providing care.

We recommend that the service seek advice from a reputable source on effective safeguarding including making alerts and record keeping.

Requires improvement

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA sets out what must be done to make sure that the rights of people who lack mental capacity to make decisions are protected in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

All necessary applications for DoLS authorisations had been made. However, contrary to due process, inappropriate applications and urgent authorisations had also been made for people who had the capacity to decide to live at the home for the purpose of receiving care and treatment. This demonstrated a lack of understanding by the management.

For people who had capacity to decide on their care and residence, the service had systems to obtain consent. However, we noted that all necessary assessments of capacity and best interest decisions to underpin care plans were not in place for people who lacked capacity to decide.

The best interest decisions that were in place on people's files did not meet the requirements set out in the MCA Code of Practice to record how the decision about the person's best interests should be reached. Including: the reasons for reaching the decision, who was consulted to help work out the best interests, and what factors were taken into account. The registered manager showed us the services' replacement best interest recording form which we noted would better enable proper recording to take place.

This was in breach of Regulation 11(1) (2) (3) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We found there was good awareness among staff of the MCA and the concept of capacity. There was also a strong understanding that whether people lack capacity or not, they must be offered choices and asked before care was given and we observed this happened in practice.

Suitable induction and on-going, up to date training were provided to staff members. This included: first aid, fire training, food safety, health and safety, infection control, safeguarding and moving and handling.

Staff members said their training and development needs were met and nursing care staff said they were enabled to meet their professional standards. Staff from overseas said they had been supported to be able to practice as nurses in the U.K. Supervision and meetings were used to embed learning, challenge practice and to identify the new development and refresher training needs of staff.

People had access to food and drink throughout the day. Jugs of water were placed around the home along with fruit and snacks to which people could help themselves. Staff support and appropriate equipment were provided to help people eat and drink. Requirements for specific diets for example, diabetic and weight gaining diets were met. For people who needed a pureed diet, each separate item of food was pureed in order to provide a dignified and more enjoyable eating experience. People's food preferences were met, for example one person preferred non-dairy milk and this was provided.

All care plans reviewed contained assessments and plans relating to nutrition and hydration. One person had been prescribed nutritional supplements following a period weight loss. Their food and fluid intake chart recorded that they were receiving this regularly. A nutritional profile was completed each month, which included their weight and body mass index. These records confirmed that the person had gained weight. Another person who was assessed as being nutritionally at risk had recorded a steady weight gain.

People were enabled to have a healthy diet of fresh food and, where possible, to make their own food choices. On the days of the inspection some people sat at tables in the dining rooms to have a home cooked breakfast, lunch and evening meal together, others had their meals in their rooms or other areas of the home. Tables were laid with napkins and place mats; the menu was placed on each table. Some people chose to have wine with their meal. Staff enabled people to make their food choices by explaining and showing them the various options.

The care plans provided information on people's communication needs and guided staff on how effective communication may be achieved. Each person had their

Requires improvement

Is the service effective?

own room that was personalised with their belongings. The home had a lifts to all floors and level or ramped access to all areas including the garden. There was good signage to help people navigate their way around the home. Bathrooms and toilets had been decorated with use of colour contrast to help people see and use the facilities more easily.

Areas of Memory Lane had been decorated and arranged to provide sensory stimulation. For example one area on the first floor resembled a small garden, complete with a water feature. A corridor had been painted with murals to resemble a street and there were benches provided to enable those who liked to walk around the corridors to sit and rest if required. A bar area was provided in one of the lounges. A hairdressing salon was also available. The wide, level corridors formed a large circuit which enabled people to walk around. The courtyard garden, located in the centre of the building, was level and secure.

Staff members were aware of the need to help people have access to health services. People and their relatives said they were provided with necessary help to make appointments and we saw evidence of this in their care records. People were registered with a general practitioner at one of four local surgeries. The GPs visited the home weekly or on request.

We saw that the service sought and followed the advice of health care professionals, for example, one person had developed bruising on their arm. Their GP was informed and, following tests, a prescribed medicine was discontinued.

Good

Is the service caring?

Our findings

People who use the service and their relatives were positive about the caring attitude of the staff. One relative said, "The carers are caring people who bother." Another relative said they felt welcome in the home and they liked the way the carers spoke and tried "to have a laugh and a joke" with their relative. One person said the carers were, "really lovely."

People said that their privacy and dignity were promoted and that staff always knocked before entering their rooms and asked before they carried out care. When we spoke to staff they described how people's privacy was protected and respect was given. They said they asked people before carrying out care and people's preferences for male or female carers were respected. Staff explained how they got to know people's history and the way they liked things to be done.

Staff members demonstrated good understanding of holistic care. A relative of a person living in Memory Lane described the care and support given as "100 % They take every care … It's just like coming to a family.''

We observed that staff members' approach was calm, respectful and valued people. They explained options and offered choices using appropriate communication skills. People appeared comfortable and confident around the staff, and were not reticent to request their help.

We saw staff work together using the correct equipment to assist a person to transfer. Staff asked before they proceeded and gently reassured the person throughout the process. We observed staff responding skilfully to people's anxieties in a way that affirmed the person's experience, calmed their anxiety and made them feel valued. During mealtimes staff were kind and respectful; they enabled independence and provided support where necessary.

No-one was receiving end of life care at the time of the inspection. In the care plans reviewed, people's wishes relating to end of life care were recorded on an 'advanced care plan'. We were informed that staff aimed to discuss people's end of life wishes on admission, or as soon as possible after.

The home used the specialist services provided by a local hospice to support people who were dying. GPs were also involved. When the person deteriorated and their end of life was imminent, then a care plan relating to their physical needs at that time, such as pain relief and hydration, would be introduced. Syringe drivers were available in order for people to receive appropriate pain relief and staff had received training in their use.

The manager said that, should relatives of friends wish to stay with a person at the end of their life, then they would be offered the use of an empty room. Reclining chairs could also be provided in the person's room or in the lounge areas.

Positive comments from relatives and friends following the death of people living in the home were found in a compliments file. One relative said "Many, many thanks for the superb care and love shown to my mother…she could not have been in a better place." Another said, "It is indeed a great comfort to the family that he was looked after by such a loving and professional team."

We noted that staff and the management team were aware of the importance of protecting people's confidentiality; it was policy for each member of staff to sign a confidentiality agreement. Records were locked away with only appropriate people having access.

Requires improvement

Is the service responsive?

Our findings

A collaborative assessment was carried out with new people coming to live at the home. Each person who used the service had a person centred care plan. This included a life history which helped to promote individuality. Care staff had a good understanding of, and were motivated to provide, person centred care which met people's needs and promoted their independence and choices whenever possible.

However, care and nursing staff informed us that because they were rushed they were unable to meet people's psychological and emotional needs as well as they would have liked. People informed us that staff were not consistently able to provide care in a way that met their needs and personal preferences.

The home took steps proactively to seek people's views, involve them in their care and respond to changes in their needs and preferences. For example, every day three people living in the home were designated 'resident of the day.' A review of their care and support was carried out. This included medical observations such as blood pressure, pulse, respirations and temperature. An audit of their medicines along with a review of their skin care and nutritional needs also took place. A whole care plan review was also completed and the person's room was deep cleaned with any maintenance work also completed. The chef would visit the person to check on the home's food offering with them.

The registered manager carried out regular residents' and relatives' meetings; these were minuted and reminded people that the staff were 'always open to suggestions to improve our service.' We could see that people were consulted, for example they were asked how they would wish to spend the residents' fund with one suggestion being a big screen projector. One recent suggestion from a residents' and relatives' meeting had been a notice board with pictures of the staff on duty for that day.

We asked for other examples of how people's requests had been responded to. The registered manager explained that some people had said they wanted to have bingo sessions. This, with the help of family members, and prizes donated by a local supermarket, had been put in place. We noted that people had been thanked for their efforts in making the bingo a success. Another request had been for more regular wheelchair cleaning in response to a family member's comments. Another request was for the return of a workshop activity in which people had been able to see and handle tropical insects.

The home carried out residents' surveys in order to gain feedback from people. At the last survey people had raised issues relating to housekeeping and staff lacking time to stop and talk to them. The responses to these concerns were displayed in the home but people informed us that staff were often rushed and that housekeeping in some communal areas was not of a good enough standard.

Regular activities were in place; during the inspection we saw that arts and crafts, a musical entertainer and bus trips took place using the service's own tail-lift bus. Other activities included: bingo, a coffee morning, a drinks and nibbles gathering, one to one chats with the activities staff, and a word game session. The service had recently had a fete and was due to have barn dance the following week end. Whilst the service had identified some improvements it wished to make in the activities programme, people were enabled to carry out activities within the service or in the community and were protected from social isolation. Family members said they felt welcome in the home.

Our observations showed that staff listened and responded to peoples' day to day requests with patience and kindness. Staff and family members said they were confident to raise any issues or concerns. There was a procedure in place to manage complaints and concerns. We were informed by some family members that they had complained to the registered manager in the previous six months. However, contrary to its policy and procedure, the service was able to provide a record of neither these concerns, nor the responses and action taken.

The registered manager said learning from a recent safeguarding process had highlighted that communication with other services, to ensure care planning and to promote people's health, safety and welfare, needed to be improved when people who stayed in The Wingfield on a short term basis left to return home. During the inspection one person was transferred to hospital. Prompt action had been taken by the nurse on duty when the person's catheter was found to be blocked and we were informed a transfer letter to the hospital was completed.

We recommend that the service seek guidance on the management of concerns and complaints.

Requires improvement

Is the service responsive?

We recommend that the service seek guidance on responding effectively to people's feedback to promote person centred care.

Requires improvement

Is the service well-led?

Our findings

We could see that information from quality and safety assurance audits was focussed on driving improvements and was included in the home's action plan of developments and improvements. In addition to the registered manager's audits which included: activities, medication, infection control, documentation and record keeping, Barchester Healthcare Homes Limited provided its own internal care quality audits and reports to the service. These were carried out by the regional manager on a monthly basis, and by the regulation team on an annual basis.

However there were areas which were either not audited, or not in a fully effective way. Or, an audit had highlighted an issue which needed to be improved, but the improvement had not taken place.

For example, in July 2015 the home's regulation team audit highlighted, 'monitoring charts were poorly completed.' During the inspection we found some monitoring charts were incomplete. The most recent infection control audit had not highlighted that people did not all have their own individual hoist slings. The auditing process did not highlight that some WC alarm cords had been tied up. A review of the daily cleaning records showed that from 22-24 July 2015 the records were not completed. These issues may have affected people's safety and well-being.

The 'keyworker data collection' forms were not being completed and had not been audited. We were informed the work that they were intended to record, keyworkers' 'meaningful interactions' with people, had not been taking place for some time. According to the residents' survey results, this had negatively impacted on people's well-being.

Not all complaints and concerns and safeguarding matters had been recorded. The falls recorded in the 'clinical governance accident list and incidents list' for The Lodge did not tally with the falls recorded on the incident and accident forms we read. Therefore it followed that these records could not accurately be evaluated for any learning and changes that may have been needed to improve the safety and quality of the service.

This was a breach of regulation 17 (1) (2) (a) (f) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We noted that many of the service's policy and procedures were based on the outdated 2010 regulations, and that the majority of these were not due to be updated until 2016. The registered manager said they would raise the issue of bringing the review date forward in order to support best practice.

When we spoke with the registered manager and staff over the three days of the inspection, we found their attitude was open; they willingly shared information in a transparent way and were able to provide the information readily. This was consistent with reports from people and staff about the open and transparent culture in the home.

The Wingfield worked in partnership including with: families, the local authority, the library service, GP surgeries, hospitals, a local hospice service and other professionals. The registered manager said that training, good communication and quality assurance systems were significant in ensuring best practice. They said that best practice information also came directly from the provider organisation; Barchester Healthcare Homes Limited.

For example, the provider issued weekly bulletins containing information and guidance to the registered manager which was then shared with staff. We saw that by this means, staff had been advised on matters such as nurse validation and the new Health and Social Care Act regulations including the duty of candour.

Many staff members had daily contact with the registered manager during morning meetings at which information was shared and suggestions could be made. For example during the inspection, the registered manager raised the issue of night staff using the call bell system to support their work.

All the staff we spoke with said they felt confident to raise any concerns. In addition to the morning meetings, the registered manager held other regular meetings for example with; registered nurses, budget holders and staff with health and safety responsibility. This meant that systems were in place for staff routinely to raise concerns. We saw that best practice issues were raised at these meetings. For example proper management of laundry was raised in the health and safety meeting. This issue was then discussed with all staff at the meeting for all departments in order to improve practice. Staff surveys were also carried out in order for the service to gain feedback from staff.

Requires improvement

Is the service well-led?

The service had development projects planned. The registered manager said that the home was introducing senior care practitioners which involved training senior care assistants to perform a more enhanced role. Also some refurbishment of the home was planned.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Insufficient care staff were deployed which meant care was not consistently provided in a timely way that promoted person centred care and reasonably mitigated risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not consistently effectively assess the risk of, detect or prevent infection and promote infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had quality and safety assurance information gathering systems in place but these were not consistently fully effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent All necessary assessments of capacity and best interest decisions for care plans were not in place for people who were unable to consent to them.