Bingley Wingfield Care Limited

Bingley Wingfield Nursing Home

Inspection report

Wingfield Court
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 April 2016 and was unannounced. On the day of the inspection there were 36 people living in the home. Bingley Wingfield provides accommodation and nursing care for up to 44 people at any one time. Accommodation in spread over three floors. The client group was mainly older people, some of whom were living with dementia.

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

At the last inspection in August 2015 we identified two breaches of regulation associated with 'Safe care and treatment' and 'Meeting nutritional and hydration needs.' At this inspection, overall we found action had been taken to address the issues we previously identified, and we found a number of improvements had been made to the service. However, we found further shortfalls which needed to be promptly addressed.

People and relatives spoke positively about the service and said they received a high standard of care and support from appropriately skilled staff.

People told us they felt safe from abuse living in the home. The service had taken appropriate action to identify and act on allegations of abuse to protect people from harm. Risk assessments were in place which assessed and mitigated some risks to people's health and safety and we saw examples of staff acting appropriately to keep people safe. However, the action taken to protect people from harm was not always robustly documented.

Safe recruitment procedures were in place to ensure staff were suitably experienced to work with vulnerable people. Although we found no direct evidence there were insufficient staff on duty, some staff told us that staffing levels were not sufficient at certain times of day. We asked the provider to investigate this and ensure that they could evidence staffing levels were based on the dependency of people who used the service.

The premises was managed safely. The service was partway through refurbishing the building and we saw a number of improvements had been made since the previous inspection; with further work planned to other areas in the near future.

Medicines were managed safely and we saw people received their medicines as prescribed.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to make choices and involved in decisions relating to their care and support.

Staff received a range of training and support to help maintain and develop their skills and knowledge. Staff told us they felt well supported by the provider and manager.

Following the previous inspection improvements had been made to the mealtime experience. People told us the food was good and we saw there were a sufficient range of options available.

People told us staff were kind and caring, treated them with dignity and respected their privacy. This was confirmed in the interactions of care and support that we observed.

We saw some good examples of staff providing responsive care that met people's individual needs. However, we identified a couple of care omissions where the required care was not provided. We also found some care plans were missing key information which meant the service was unable to demonstrate people's needs had been fully assessed.

A range of activities were available to people and we saw these were well received by people who used the service. The home also had a volunteer group whose input enhanced the social activities programme.

A system was in place to log, investigate and respond to complaints. Complaints were managed appropriately and used as an opportunity to continuously improve the service.

The provider was committed to further improvement of the service and they assured us that they were taking prompt action to address the issues we raised with them.

A number of positive systems were in place to assess and monitor the quality of the service. We saw these had been identifying and rectifying issues.

However, oversight of the lunchtime meal allocation process and people's fluid intake was not sufficiently robust.

We identified two breaches of the health and social care act 2008 (Regulated Activities 2014) Regulations. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Overall, medicines were managed in a safe manner and we saw people received their medicines as prescribed.

Information detailing the actions taken to address risks to people's health and safety was not consistently recorded.

Safe recruitment procedures were in place. Some care workers told us there were not enough staff at certain times of day.

Is the service effective?

Good

The service was effective.

People told us staff were appropriately skilled. Staff were provided with a range of training and support from management.

Overall, the mealtime experience was pleasant and people told us they enjoyed the food.

People's healthcare needs were assessed and people had access to a range of health professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity from staff who worked at the service. Where appropriate, people's independence was promoted.

People's views were listened to and acted on by the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although we saw some instances of good person centred care, this was not consistently the case. Some care plans were missing

key information.

A system was in place to log, investigate and respond to complaints in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Although improvements had been made to the service following the previous inspection, there were further areas that required attention to ensure a consistently high quality service.

A range of audits and checks were undertaken on the service. The quality of these varied with some audits not being sufficiently robust.

People's feedback was sought through various mechanisms and their comments acted on.

Bingley Wingfield Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also followed up on breaches of regulation identified at the August 2015 inspection.

The inspection took place on 26 April 2016 and was unannounced. The inspection team consisted of three adult social care inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 13 people who use the service, six relatives, six care workers, the cook, a cleaner, the activities co-ordinator, the registered manager and the provider. We observed care and support in the communal areas of the home for six hours. We looked at seven people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority.

Requires Improvement

Is the service safe?

Our findings

People's care records contained risk assessments for example for falls, nutrition and tissue viability. We saw where some risks had been identified action had been taken to mitigate the risk and this had been documented. For example, one person had been assessed as being at risk of skin damage. We saw they had a specialist mattress in place and they were having barrier creams applied to particular high risk areas. We saw another person had a specific health condition which meant they sometimes experienced problems breathing. A care plan had been developed which detailed what actions staff should take to monitor and manage this risk. This included specific descriptions of what to look for when this person may be beginning to experience breathing problems. We spoke with staff about this person. What they told us matched the information within the person's care records which demonstrated they had a good knowledge of how to manage this risk. This was confirmed by the person who told us, "Staff know when I am having problems and are there like a shot to help me and get me the medicines I need. I can usually manage this myself but I feel so much safer knowing staff are there if I need them."

However, it was not always clear in care plans what measures had been taken to mitigate identified risks. For example, we saw one person had lost 10kgs in weight over a two month period. There was nothing documented in the care plan about any specific actions staff had taken in relation to this. We saw on the healthcare records they had been seen on three occasions by their GP, regarding the weight loss and the registered manager told us they had spoken with the GP again on 25 April 2016, but had not documented this in the records. Staff told us, and the records confirmed, this person had drunk and eaten very little over the previous week. We saw staff trying to encourage them with foods they liked, but the person just pushed them away. We also saw staff gave them a fortified drink, which they drank very little of. We concluded staff were likely taking action to support this person with their diet, but the records did not fully demonstrate this.

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

People told us that they felt safe in the company of staff, for example when staff were assisting them to use equipment and when providing personal care. People said that staff delivered care in a kind and gentle manner. One person told us staff were, "always popping in" to see if they were okay and that night staff were "good, they check me two hourly."

Safeguarding procedures were in place and we saw evidence these had been followed to help keep people safe. Where safety related incidents had occurred, appropriate preventative measures were put in place to reduce the risk of a re-occurrence and safeguarding people from harm.

We assessed staffing levels within the home. Staffing levels were one nurse on duty at all times. Six care workers worked the morning shift until 2pm and then one nurse and four care staff until 8pm. At night one nurse was on duty with two care workers. These staff were supported by cooks and domestics seven days per week and an activities co-ordinator. We observed care and support within the home and found overall people were provided with sufficient interaction and prompt care intervention. However, there was a lack of

interaction provided within the ground floor lounge at times. Care workers we spoke with told us they thought they needed more care staff in the afternoons, evenings and at night. Although we did not find any conclusive evidence that staffing levels were unsafe we were concerned that there was no formal process to determine staffing levels based on the dependency of people who used the service. We asked the provider to review staffing levels particularly in the evening and overnight periods to provide assurance that they were safe at all times.

We recommend that the service utilises a recognised tool to monitor whether staffing levels are sufficient taking into account the needs and dependencies of people who use the service.

When we inspected the service in August 2015 we found some improvements were required to the medicine management system and made a recommendation around ensuring medicine stocks were robustly managed and "as required" protocols put in place. At this inspection we identified that these areas had improved. Some people had medicines which had been prescribed to be taken as needed. When this happened we saw there was guidance in place for staff to follow. This showed us there were measures in place to make sure these medicines were used consistently. We checked the stock balances for eight medicines prescribed to be taken as needed and found they were correct. This showed us medicines were being managed safely and medicines could be accounted for.

People told us they received the required support with their medication. For example, it was brought on time and they received the required pain relief. We observed the morning medicine round and saw the nurse spent time with each individual and supported people with patience and kindness to take their medicines.

We found medicines were stored securely. The temperatures of the storage area and fridge were monitored to make sure medicines were stored at the recommended temperatures. Medicine trolleys were clean, tidy and well organised.

We saw people's medication administration records had been signed consistently, showing people had been given their medicines as prescribed. Some medicines are issued with instructions about how they should be taken in relation to food. For example, some needed to be taken 30 to 60 minutes before food. We found there were suitable arrangements in place to make sure these instructions were followed and these medicines were being given by the night staff.

When people were prescribed topical medicines such as creams and lotions we found body maps had been put in place to guide staff on where and how often to apply these medicines. However, we found staff were not consistently recording if the prescribed creams and lotions were being applied as directed.

We undertook a tour of the premises. The building had measures in place to restrict access to hazardous areas such as staircases. There were adequate numbers of communal areas available for people to spend time including a newly refurbished terrace area downstairs and adjoining garden area which provided a secure place for people to spend time outdoors. Discussions with the provider and registered manager showed the home was partially through a programme of significant investment which aimed to improve the environment. A number of bedrooms and some communal areas had been redecorated and refurbished and were pleasant and homely. Some other areas required attention, for example, the décor in some of the corridors where doors were stained with paint. However, we were assured by the improvement plan that action would be taken to address these areas in the near future. A maintenance worker was employed who operated a system to ensure building faults were reported and promptly repaired. Regular checks and maintenance of safety related building systems such as fire, water, electrical and gas were in place to help keep people safe.

We identified there was an odour of stale urine in the two lounges near the main entrance. We also noted other areas where there were other unpleasant smells. One relative told us younger members of the family did not come to visit because of the smell. The provider told us they would look into this and were looking at replacing the chairs in the main lounge which had been identified as one source of the odour.

Robust recruitment procedures were in place to ensure staff were of suitable character for the role. This included ensuring candidates completed a full application form, and attended an interview to assess their suitability. New staff were subject to identify checks, a DBS (disclosure and baring service) check and obtaining references from previous employers. This helped to ensure people were cared for safely by staff.

Good

Is the service effective?

Our findings

People spoke positively about the staff who cared for them. We spoke to care workers who confirmed they received appropriate training and that their training was kept up to date. They told us they thought the staff team was good and worked well together and that they received good support from management.

Training records showed staff received a range of training and demonstrated a good knowledge of the subjects we asked them about. Training was provided to staff on induction, although the service had not yet adopted the Care Certificate which helps ensure staff receive training in a broad range of subjects to meet national standards. Training was provided as part of an annual training programme which included, safeguarding, manual handling, dignity, infection control, fire and mental capacity act (MCA). Training was delivered face to face and it was clear the service had taken the time to plan high quality training which had been delivered by people with an appropriate level of expertise. Specialist training had been provided to some staff which included end of life care. An end of life champion had been appointed by the service to help promote good care and practice in this area.

Individual and group supervisions sessions had been completed to address deficiencies in staff skills and to promote subjects such as record keeping, nutrition and hand hygiene. Staff received annual appraisal to assess their performance and discuss their developmental needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had assessed the restrictions placed on people and made appropriate DoLS referrals to the supervisory body. Three DoLS authorisations were in place with other applications awaiting assessment by the supervisory body. We spoke with care staff about two people who had DOLs authorisations in place and they had a practical understanding of what it meant for each person and the care they provided. However, we did identify a lack of care plans developed for people with DoLS authorisations, detailing how staff were to provide care in the least restrictive way possible. A system was in place to monitor DoLS applications and authorisations to establish whether they needed to be reapplied for. The provider and registered manager had a good understanding of the MCA and DoLS which gave us assurance that the correct processes would continue to be followed.

We saw the service had helped people access Independent Mental Capacity Advocates (IMCA's) where appropriate to help ensure their rights were protected.

When we inspected the service in August 2015 we found the meal time experience for people required improvement. Overall we identified significant improvement had been made to the mealtime experience. We saw the provider was monitoring the dining experience and this assured us further inconsistencies we identified would continue to be addressed. We asked staff what had improved since our last inspection in August 2015. One care worker told us, "Meal times are more organised, we have supplies of cutlery, clothing protectors, plate guards and tissues in the lounges so we don't have to keep going up and down to the kitchen."

People told us they got plenty to eat and drink. They said they enjoyed the food, for example one person said it was "excellent." Another person told us, "The food is always brought to you and properly served. It's not just thrown at you. This makes meals a more enjoyable experience." A third person said, "The food is good, I like my food" and a fourth, "The food is good, varied and there is choice." A fifth person told us, "The food is fine, there is a choice and yesterday I had one of my favourites, scampi." People told us they were offered a choice of a cooked breakfast in the morning and two meals at lunch with alternatives if they didn't like what was on the menu.

We observed breakfast and lunchtime meals. Meals looked hot and appetising. We saw people enjoying their meals and staff offered people second helpings. We saw breakfast was relaxed with people coming into the dining room at different times. When people arrived they were promptly provided with a drink and asked what they would like for breakfast. People were offered a number of options including a choice of cereals or porridge, white or brown toast with jam or marmalade, yogurt and various cooked breakfast items. We saw one person did not have their breakfast until 10am. They told us this was because they wanted to have a lie in. They said they sometimes had their breakfast in their bedroom but wanted to sit in the dining room today. This showed us people had a choice about when and where they took their meals.

At lunchtime, people were asked first if they wanted a clothes protector and if they were ready for their plates to be taken away after the meal. We saw one person did not like either of the main meal options so the kitchen made them scrambled eggs as an alternative. However, people's lunchtime time experienced varied depending on which floor they took their meal. For example, on the first floor people were offered tea, coffee or juice with their lunch. On the ground floor people were offered juice with their meal and a hot drink after. On the first floor no one was offered and condiments, but condiments were in use on the ground floor.

Nutritional risk assessments were completed on admission and people's weight was monitored. Where there were specific nutritional risks we saw information within people's care records to guide staff about what action they should take to reduce the risk. For example, we saw one person had their drinks thickened due to having swallowing difficulties. We saw information about this within the person's care records including detailed instructions from the Speech and Language therapist about how their fluids should be thickened; this information was also available in the kitchen. We spoke with care and kitchen staff about this person and they were aware that their fluids were always thickened and were aware of how to do this.

We spoke with the kitchen assistant and they had a good understanding of people's dietary needs. Menus were planned with input from people who used the service and were planned to ensure people received a varied and balanced diet. Information about peoples' specific preferences and needs was kept in a file in the kitchen so staff could refer back to it as they prepared and planned meals.

We spoke with the care workers who told us if they report any change in people's well-being the nursing staff were quick to respond and involved other health care professionals as necessary.
In care plans we looked at we saw people had been seen by GPs, specialist nurses, opticians and podiatrists. We also found information recorded about any contact by healthcare professionals, either in person or by

telephone, recorded in the care file. This meant it was easy to find out about any treatments or instructions and that people's health care needs were being met One person's relative described how staff had helped to rehabilitate their family member. They described how their relative had been very poorly when they moved in to the home but said staff had delivered such effective care that they had, "Given them back their confidence and brought them back to life."

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about staff and the standard of care they provided. One person who used the service told us, "I would never want to be anywhere else now. I specifically asked to come here. I told people get me a place at Bingley Wingfield or take me home as I won't go anywhere else. Everything here is first rate." A relative told us, "Staff genuinely care about people and treat each person as an individual." Other comments included: "I'm happy here, I like the people, and we have a chat and a giggle. I've had no cross words with any of them," "They are gentle; they know I am wobbly on my feet. Lovely people" and "They are caring, polite, cheerful and I wouldn't fault them in that respect."

The interactions we observed in communal areas confirmed what people told us. We saw staff were kind and familiar with people and that relations with them were relaxed and warm. We saw people were spoken to politely and respectfully at lunch time. Throughout the inspection we heard staff speaking to people in a respectful way and getting down to their level when they were seated.

People told us staff helped preserve their privacy and dignity. One person described how staff used privacy curtains and covered them up when providing personal care. Another person told us, "Staff are simply superb. They are so polite and speak to you with such respect. I always get privacy when I need it." We saw staff provided prompt and discreet support with personal care. Before lunch staff overheard one person comment that their cardigan was too small, staff promptly supported the person to change it. Afterwards the person commented that they, "Felt much better now."

People told us they had "usual carers" and were generally cared for by familiar faces which led to good relationships developing between staff and people who used the service. One person told us, "The staff are kind and there are consistent staff who care for me." A relative told us, "There is consistency of carers, which is very good. The staff are helpful and kind." People told us they knew carers by their names for example one new resident said "I can put names to faces now" and another person said "X is my usual carer, he's good, he gets me up." We saw care staff approached people in a way which showed they knew the person well and knew how best to assist them. We saw several examples where staff took prompt and effective action to keep people calm, reduce anxiety and provide reassurance where needed. This showed us staff knew potential triggers and effective strategies to help reduce anxieties.

We saw staff engaged with people socially, for example, reading the paper to someone in the upstairs lounge. This made for a pleasant atmosphere. We saw one person being moved from their wheelchair to an easy chair by two care workers using the hoist. Staff talked to them throughout the manoeuvre offering support and reassurance.

We saw staff helped people to maintain their independence where ever this was possible. One person described how staff had provided their drinks in a specialist cup. They told us, "This may only seem like a small thing but it means I can have a drink without needing staff's support and without worrying I will spill it." Another person described how staff had helped build their confidence and they could now do much of their personal care independently. They said, "You get support where you really need it, but otherwise staff

encourage you to do things for yourself."

Relatives we spoke with told us staff were friendly and made them feel welcome and sometimes they were offered a drink.

People told us they felt listened to and we saw staff offered people appropriate choices. Where people were unable to communicate their choices staff knew their preferences. However, we identified that pictures could be used to promote understanding, for example, at mealtimes, this would particularly help people living with dementia. We saw this had been identified on the provider's actions plan. People were encouraged to voice their opinions on their care through care plan reviews and resident meetings. We saw examples where people's opinions had been used to inform future plans of care.

Systems were in place to ensure people received a dignified and appropriate end of life experience. An end of life champion had been appointed and we saw evidence they had been involved in meetings with staff to promote the subject. End of life care plans were in place and the service used a coding system to establish people's needs.

Requires Improvement

Is the service responsive?

Our findings

We saw some good examples of staff responding well to people's needs. For example, staff noticed one person was learning to the side and immediately brought a cushion to offer them more support. In another instance a person's teeth were slipping when they were eating their meal and one of the carers who noticed this, fixed them with some adhesive so they could eat more comfortably. We saw staff listened to people's views and promptly responded to try and accommodate their requests. For example, during lunch we saw one person pushed their main course of savoury mince away and said they did not wish to eat it. Staff promptly offered them the second hot meal choice of fish cake, which the person declined. Staff asked whether they would prefer a sandwich and offered a range of different fillings. The person chose a sandwich and this was promptly made and brought to them. We heard the person say this was "Much more enjoyable."

However, we identified a lack of organisation of staff working practices within the home lead which led to some isolated instances of sub-optimal care for some people who remained in their rooms. For example, when we visited one person's room at 11.00am and again at 14.00 their commode was full of urine. We concluded through our observations and review of records that it had not been emptied during this period by staff. Records showed staff had last checked on this person at 10.15am with no further documented checks undertaken until after 14.00. As such on the inspection date, we were also unable to confirm whether they had been offered any lunch despite enquiring with the kitchen. Following the inspection this was investigated by the provider and an update provided to the commission which provided us with assurance the matter was being addressed. We also found an instance in one person's room where staff had not promptly cleared up a small amount of bodily fluid on the wall by the bed despite staff regularly visiting the room to check if the person was okay.

We saw in one person's care plan they required a 'full body wash' every day as they were being nursed in bed. When we spoke with this person they told us they had a wash every day, but not necessarily a full body wash. This demonstrated to us staff were not following the care plan.

We saw one person had a urinary catheter in place to help them to manage their continence. There was no care plan in place to inform staff what support they needed to offer, to ensure the person's safety and comfort. The provider agreed there should have been a care plan in place.
We saw two people were sat in their wheelchairs at one of the dining tables in the lounge all day. Both were sleeping for long periods and one person's head was at times on the table. Neither was offered to transfer to an easy chair. We asked care workers if either person went for a rest on their bed in the afternoon. They told us they did not. We concluded people's comfort and need for rest needed to be addressed through the care planning process.

Care plans were reviewed each month however, we saw changes were not always being translated back into care records. For example, one person had a DoLS authorised in August 2015. Despite being reviewed each month their 'wandersome behaviour' care plan and monthly review records did not mention the DoLS had been applied for or authorised and their care plan was not updated to explain how this impacted upon the

person. The only information available to staff about the DoLS was a copy of the application and authorisation forms. This meant an individualised care plan was not in place to ensure staff chose the least restrictive option when supporting this person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

We saw people's needs had been assessed before they moved into the home. These gave an overview of people's care and support needs and any equipment which would be required. For example, requires a soft diet, specialist mattress. People had a range of care plans in place which provided staff information on how to provide appropriate care, for example, around continence and eating and drinking.

When we looked at the care plans we found no information about people's life histories or personal preferences. We spoke to a care worker about one person who had moved in to Bingley Wingfield recently and they agreed having this information would be helpful so they could understand them what their interests were. This information helps staff to understand the person and their background in order to provide more person centred care. The provider and manager were working on life history information, however, this needed to be resolved more promptly as it was identified at our previous inspection.

Since the last inspection, people and their relatives had been involved in comprehensive reviews of their care. We saw these reviews had led to information about people's preferences and changes they wanted being incorporated into their care plans. We looked at the reviews which were overwhelmingly positive and showed most people were very happy with the standard of care received at the home.

The provider and registered manager were in the process of updating the 'resident handbook.' This was being done to ensure it provided clear and relevant information on the service and about how they could become involved in the service.

An activities co-ordinator was employed and usually worked five days per week. The registered manager explained that a formalised activities programme was not in place because staff liked to be guided by what people wanted to do on a day to day basis. During our inspection we saw the activities co-ordinator was based in the downstairs dining room. They were skilled at encouraging people to join in with activities and we observed lots of smiling, laughter and positive comments which showed us people enjoyed the activities on offer. On the day of our visit we saw the activities included board games, knitting, quizzes, dominoes, bingo and memory games. Care staff worked hard to try and ensure everyone had something to do. For example, where people did not wish to participate in group based activities staff provided magazines and papers and spent time discussing the news with people.

People told us staff tried to ensure activities matched their individual interests. For example, one person described how they preferred more creative pursuits so staff had bought them paints and wool so they could spend time knitting and doing arts and crafts because they did not like playing games. Their relative told us, "The activities are personalised. It's so lovely to see [my relative] knitting again, I haven't seen them knit in over four years but staff here have got them back into it." People also told us they particularly enjoyed the musical entertainers who visited the home each month and had also enjoyed the recent trip which staff had organised to a local garden centre. One person told us this trip had been, "The most perfect day."

On the morning of our inspection the hairdresser was based in the dining room. This meant there was less space available for people to participate in the group based activities. We saw three people were supported to move to another table to accommodate the hairdresser. This caused one person to become confused. We

also saw two people were supported down to the dining room during this time and appeared keen to participate in the activities. However, as there was no space they were supported back upstairs to the main lounge. We raised this with the provider and they said they would look for alternative space to accommodate the hairdresser.

The service also benefited from a volunteer, group 'Friends of Wingfield' who organised events to help meet peoples' social needs. We spoke with the chair of this group who told us about a number of social events that had occurred including a recent trip to a garden centre.

Complaints were managed appropriately. We saw the complaints procedure was on display in the home. People told us complaints were appropriately managed. One relative told us, "[the registered manager] is approachable and I would feel able to raise any concerns with her."

Information on how to complain was displayed throughout the home. We saw a small number of complaints had been received in the last 12 months. These had been appropriately logged and showed thorough investigations had taken place into the concerns. Where appropriate, recommendations had been made and implemented which demonstrated a commitment to learning from adverse events. Meetings were routinely held with people following complaints to discuss the outcomes with the complainant. A significant number of compliments had been received about the service which were logged so that service was aware of the areas it exceeded expectations.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place. We found the required statutory notifications had been submitted to the Commission. For example, notification of deaths and serious injuries. This allowed us to monitor events that occurred within the service.

Staff and people who used the service spoke positively about the registered manger and said they addressed any issues that were raised. One care worker told us, "[registered manager] is approachable and you can go to her." Staff feedback was also sought through an annual staff questionnaire. We reviewed the responses from this which were mostly positive showing staff felt well supported by the organisation. Where negative comments were received, we saw an action plan was in place to address the issues raised.

We found the registered manager and provider were open and transparent with us about where the service currently was and about further improvements that were required. We identified there had been a number of improvements made since the last inspection and the provider demonstrated a commitment to further continuously improve and address the risks we identified during this inspection. The provider told us they were not allowing the home to be filled to capacity at present until the remaining quality issues within the service had been addressed. A service improvement plan was being utilised to drive this improvement within the home. We saw a substantial number of actions had been signed off since the last inspection in August 2015, with further development planned, for example, to the building, service user guide and life history work.

The registered manager was required to complete a monthly submission to the provider to inform them of events within the home .For example, this looked at complaints, concerns, safeguarding and health and safety. The provider then reviewed this and asked the registered manager to complete an action plan where appropriate.

The provider conducted a number of observations such as, the mealtime experience. We looked at the last few of these which demonstrated a number of issues had been identified but showed an improving picture. For example the last audit showed fewer issues had been identified and demonstrating improvement of the service. Others systems were in place to improve working practices within he home. For example, when areas for improvement had been identified such as the mealtime experience, safety of equipment and hand hygiene, group supervisions had been held with staff to discuss what changes they needed to make to their practice.

Regular medicine audits were undertaken by the registered manager. We looked at recent audits and saw they had been effective in identifying and rectifying issues. These were then reviewed by the provider. Annual infection control audits were undertaken and daily cleaning schedules were completed. Systems were in place to monitor DoLS applications, people's weights and staff training.

However, we identified some poor practices which could have been identified and rectified through more robust monitoring. For example, we could not establish whether one person had been offered any lunch

and the system operated by the kitchen was not sufficiently robust to provide assurance that every person had received their midday meal. We identified care workers were completing food and fluid charts for some people. However, there was no information recorded about the optimum fluid intake each person should seek to achieve. Staff were not making an assessment as to the adequacy of people's overall food and fluid intake. For example, one fluid chart we looked at indicated the person had only drunk 550mls in 24 hours. Using current guidance their recommended intake should have been 3420mls. This should have been identified and monitored through a robust system of quality assurance.

Care plan audits were undertaken, however, no comprehensive care plan audits had been completed since October 2015. Those conducted prior to October 2015 did not contain an action plan to address issues found. Due to us identifying a number of inconsistencies with care plans we concluded a more robust audit system could have been in put in place.

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

Methods were in place to seek feedback from people who used the service. The provider had previously sent annual satisfaction surveys to people, however, they had received a poor response. People's feedback was sought through the annual care plan reviews and showed people were very happy with the service. For example, one comment read, "Can only say care is excellent could not wish for anything better. Staff are friendly and helpful." Periodic resident meetings were held and we saw evidence that topics such as activities and food were discussed as well as informing people of any changes around the home.

Incidents and accidents were recorded and these were analysed at the end of each month to look for any trends, such as whether there were any pattern in the occurrences of falls within the home. This helped ensure people were kept safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 9 HSCA RA Regulations 2014 Person-centred care (1a) Care and treatment of service users was not always appropriate. (2a) A complete assessment of people's needs was not always carried out.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1) 2a Systems to assess and monitor the quality of the service were not sufficiently robust. 2c An accurate and complete record of the care each service user was receiving was not consistently in place.