Buckland Care Limited

Inglefield Nursing & Residential Home

Inspection report

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Date of inspection visit:
15 August 2018
16 August 2018

Date of publication:
03 October 2018

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 August 2018 and was unannounced.

Inglefield Nursing & Residential Home is a 'care home' and is registered to accommodate up to 49 people who require nursing or personal care. At the time of the inspection 39 people were accommodated at the home. People in care homes receive accommodation and personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection. This home provides a service to older people some living with dementia or mental health needs.

The home had a registered manager. 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 our last inspection, in July 2017, we identified breaches of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with consideration and quality assurance systems were not always effective. At this inspection, we found action had been taken and there were no longer any breaches of regulation. However, further improvement was still required.

Although new quality assurance procedures had recently been put in place, these needed further development and time to become embedded in practice and bring about the necessary improvement.

People had mixed views about the adequacy of staffing levels. Although we found these were adequate to meet people's essential needs, we could not be assured that people's call bells were always responded to in a timely way.

Recruitment procedures were not followed consistently, so the provider was unable to confirm that all staff employed were suitable.

Medicines were generally managed safely, although medication administration records had not been completed fully, some medicines could not be accounted for and there was a lack of information about when and how 'as required' medicines should be given.

People's rights and freedom were not always protected. Although staff said they acted in people's best interests, they did not always document decisions they had taken on behalf of people. There was no process to ensure applications were made to renew legal restrictions imposed on people's freedom and staff did not know which people were subject to such restrictions.

People told us staff were competent and provided effective care; however, some staff training was out of

date. Although nurses usually followed best practice guidance, we found they did not take a consistent, evidence-based approach to supporting people with diabetes.

Staff demonstrated a good awareness of the individual support needs of people living at the home. However, people's care plans did not always support staff to deliver care in a personalised way; they lacked information about the support people needed when they became agitated and people's end of life wishes and preferences had not been recorded.

Staff were appropriately supported in their role through one-to-one sessions of supervision, staff meetings and observations of their practice. Although some staff appraisals were overdue, plans were in place to complete these.

There was an open and transparent culture where visitors were welcomed. However, written information had not been provided to the family of a person who came to harm.

Individual and environmental risks to people were usually managed effectively and there were systems in place to protect people from the risk of infection.

People told us they felt safe living at Inglefield and staff understood their responsibilities to safeguard people from harm.

People's nutrition and hydration needs were met and most people were satisfied with the quality of their meals.

Some adaptations had been made to the environment to make it supportive of the people who lived there and further enhancements were planned.

People were supported to access other healthcare services and information was made available when they were admitted to hospital, to help ensure the continuity of their care.

People consistently told us they were treated in a kind and compassionate way and we observed positive interactions between staff and people. Staff encouraged people to be as independent as possible and involved them in discussions about their care.

People had access to a range of activities based on their individual interests, including on a one-to-one basis.

There was an accessible complaints procedure in place. People told us they felt able to raise concerns and were consulted in a range of ways about the way the service was run.

Staff communicated effectively between themselves. They told us they were happy and motivated in their work and demonstrated a willingness to learn from mistakes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People felt there were enough staff to meet their needs, although at times they said they had to wait for support.

Appropriate recruitment procedures were in place, but these were not always followed to ensure staff were suitable for their role.

Medicines, including 'as required' medicines were not always managed safely.

Individual and environmental risks to people were usually managed effectively. There were systems in place to protect people from the risk of infection.

Appropriate systems and processes were in place to protect people at risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff acted in people's best interests, but did not always record decisions they had made on behalf of people. Staff were not aware of which people were subject to restrictions of their freedom.

Staff were competent and understood people's needs. However, some staff training was not up to date and nurses did not always take an evidence-based approach to diabetes care.

Staff were appropriately supported in their role by managers.

People's nutrition and hydration needs were met and people were satisfied with the quality of their meals.

Adaptations had been made to the home to help make it supportive of the people who lived there and further work was planned.

Staff supported people to access other healthcare services and made appropriate use of technology to support people.

Is the service caring?

Good

The service was caring.

People were treated in a kind, considerate and compassionate way by staff.

Staff used appropriate techniques to communicate effectively with people.

Staff respected people's beliefs and supported them to follow their faith.

Staff encouraged people to be as independent as possible and involved people and their families, where appropriate, in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual needs were met. However, care plans did not always support staff to deliver care and support in a personalised way and behavioural support plans had not been developed where needed.

Staff supported people at the end of their lives to ensure their comfort and their dignity, but had not developed end of life care plans or recorded people's wishes and preferences.

Staff were responsive to people's changing needs and supported people to access a range of activities suited to their individual interests.

People knew how to raise a complaint and there was an accessible complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a new quality assurance process in place, but this needed further development and time to become fully effective and embedded in practice.

There was an open and transparent culture where visitors were

welcomed. However, the duty of candour requirements had not been followed fully.

People were generally satisfied with the way the service was run and were consulted about aspects of the service.

Staff were organised and communicated effectively between themselves. They demonstrated a willingness to learn from mistakes.

Inglefield Nursing & Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 16 August 2018 and was unannounced. It was completed by an inspector, a specialist advisor in nursing care 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spoke with 17 people who used the service and eight friends or family members of people who used the service. We spoke with the provider's general manager, the registered manager, the deputy manager, the clinical lead nurse, two registered nurses, a support nurse, the head of care, seven care workers, a management support worker, a cook, a maintenance worker, an administrator and two housekeepers. We received feedback from an advanced nurse practitioner and two 'Relevant person's representatives'. A relevant person's representative is an independent person, appointed to act on behalf of people whose liberty is restricted and who do not have relatives to advocate on their behalf.

We looked at care plans and associated records for nine people and records relating to the management of the service, including: duty rosters, staff training and recruitment files, records of complaints, accident and incident records, maintenance records and quality assurance records. We also observed care and support

being delivered in communal areas of the home.

We last inspected the service in July 2017 when two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and we rated the service 'Requires improvement' overall.

Requires Improvement

Is the service safe?

Our findings

We found there were enough staff deployed to meet people's essential needs, although we received mixed views from people and staff about this and some said they often had to wait for their call bells to be answered. Comments from people included: "They [staff] don't always come quickly; you can sometimes wait a long time", "I feel they are under-staffed. There's an ever present danger they might not get to me in time [to use the bathroom]" and "There are not enough staff here". A family member told us, "Two staff are needed to attend to my [relative's] needs; sometimes this is not possible and she has to wait." However, more positive comments included: "There seem to be enough staff most of the time" and "The fact they [the provider] are using agency staff show they have identified the problem and are addressing it."

Staff also had mixed views about the adequacy of staffing levels, but all told us they felt people's needs were met. Comments from staff included: "There are not enough staff. The early shift is usually okay, but we can be quite short on lates and struggle to get people back to bed; it's a mad rush seeing to so many people", "We do struggle on the evening shifts; it's not fair on the residents as we don't have time to chat with them" and "There are not enough care staff. If one goes sick, it has an impact as there's no fat to fall back on. The [care] staff are amazing, but I feel for them, they are run ragged". More positive comments included: "I think there are enough [care staff] and there is always at least one nurse and a support nurse on in the day and a nurse at night" and "Staffing is okay apart from the odd days when [staff] call in sick. We cover as best we can and responses to call bells are getting better".

The registered manager told us staffing levels were calculated using a tool that took account of the dependency levels of people using the service. However, the tool did not consider the size or layout of the building, which was large and complex, and the provider had not conducted any analysis of call bell response times to assess whether these were adequate. We discussed this with the provider's general manager and by the end of the inspection they had obtained approval from the provider to upgrade the call bell system to enable them to conduct this analysis and properly assess whether there were enough staff to support people effectively.

We looked at the duty rosters for a four week period leading up to the inspection. These showed the staffing levels (as calculated by the provider's dependency tool) had been met on all but three occasions. This had been achieved through the use of agency staff, up to 700 hours per month from two agencies. During the inspection, we saw call bells were responded to promptly and people's care records showed they had been supported in a timely way.

The provider had clear recruitment procedures in place, although these had not been followed consistently. The procedures required applicants to complete an application form, to provide a full employment history and be subject to pre-employment checks, including references, before they started work at the home. References enable an employer to take account of the applicant's past performance and behaviour when considering their suitability to work with adults at risk. A reference for one staff member revealed they had recently been dismissed while working for a care provider; although they had worked for two other care providers in the previous three years, further references from those care providers had not been sought to

verify their conduct. The provider had not confirmed the staff member's conduct in those posts or their reasons for leaving, so were not able to assess whether this might affect their suitability to work with adults at risk. For two other staff members, we found there were unexplained gaps in their employment histories; the provider was, therefore, unable to consider whether the reasons for the gaps impacted on the staff member's suitability for their role. We discussed these issues with the registered manager who immediately put more robust procedures in place to help ensure pre-employment checks were completed and monitored consistently.

In all cases, we found checks had been made with the Disclosure and Barring Service (DBS) before staff started work at Inglefield. The DBS helps employers make safer recruitment decisions by disclosing any previous convictions held by the applicant. In addition, checks were made with the nurses' regulatory body to ensure the nurses were registered to practice.

There were arrangements in place for medicines to be obtained, stored and disposed of safely.
Oral medicines were administered by nurses or support nurses who were suitably trained and had been assessed as competent, while prescribed topical creams were usually applied by care staff. Staff used medication administration records (MARs) to record when they had administered medicines and were required to initial the MAR charts to evidence this. We noted the MARs contained occasional unexplained gaps where staff had not initialled the MAR chart but we found the relevant medicines were no longer in their pre-prepared packs, indicating they had been given. Everyone we spoke with confirmed they had received their medicines as prescribed. Some people's medicines were kept in boxes rather than pre-prepared packs. However, when new boxes arrived at the start of the month, staff did not carry forward the existing stock onto the next month's MAR chart; this meant they were not able to account for the number of tablets in stock at any one time and would not be able to identify if any had gone missing.

For people prescribed 'as required' medicines (PRN), we found there was a lack of information about when and how these medicines should be given. For example, they did not specify the time gap between doses or other strategies that could be used to support people who become agitated, before resorting to the use of sedatives. The provider's policy required that an explanation was recorded on the back of the MAR chart when a PRN was given, but we found this was not consistent; for example, one person had received PRN medicines on 17 occasions, but the reason for their use had only been recorded on five occasions. Whilst regular staff knew when to use PRNs, agency staff would not have that level of insight and this posed a risk that they might not be used in a consistent way. We discussed the above medicine issues with the clinical lead nurse who agreed they were areas for improvement. The need for more PRN information had also been identified in a recent audit by the provider and the registered manager told us this work was in hand.

Individual risks to people were usually managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. One person had been assessed as at high risk of choking and there was a clear plan requiring staff to support the person to eat slowly with a teaspoon. Although most staff did this, we observed one staff member supporting the person with a dessert spoon; this put them at increased risk of choking and we had to intervene to prevent the dessert spoon being used. We raised this incident with the registered manager who undertook to remind staff of the need to use a teaspoon.

People were protected from the risk of falling. One person told us, "They [staff] wouldn't dream of letting me shower on my own as they worry about me falling and bleeding. They also come with me when I go in the garden." Where people came to harm, the provider had procedures in place to investigate and analyse the causes, learn lessons and take remedial action to prevent a recurrence. For example, analysis showed one person had a history of falling just before teatime. Staff had identified that this was due to the person

becoming hungry and restless, so brought the person's teatime forward which had reduced the frequency of their falls.

Other people were at risk of developing pressure injuries and we saw care plans had been developed to reduce these risks. These included the provision of pressure-relieving mattresses, the use of barrier creams and regular repositioning. There was a clear process in place to help ensure the pressure mattresses remained at the right setting according to the person's weight and 'turn charts' confirmed that, where needed, people were supported to reposition regularly.

Environmental risks were managed effectively. Maintenance staff checked the temperature of hot water outlets on a monthly basis, including those in people's rooms. Gas and electrical appliances were serviced routinely and fire safety systems were checked weekly. Staff were clear about what to do in the event of a fire and had been trained to administer first aid. Furthermore, each person had a personal emergency evacuation plan (PEEP) detailing the support they would need if the building needed to be evacuated. All equipment used in the home was checked and maintained regularly to help ensure it was safe to use; this included bed rails, suction machines and the automatic external defibrillator.

There were systems in place to protect people from the risk of infection. We found all areas of the home were clean and cleaning records confirmed they were cleaned regularly, in accordance with a cleaning schedule. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed. They described how they processed soiled linen, using special red bags that could be put straight into the washing machine. Within the laundry, there was a clear system to help prevent cross contamination between dirty linen entering the laundry and clean linen leaving it. Although there was not a dedicated hand washing sink for staff to use, we saw the need for this had been identified in a recent audit and one was due to be installed after the inspection.

People told us they felt safe living at Inglefield; for example, one person said, "I feel safe and comfortable here." The provider had effective systems and processes in place to protect people at risk of abuse. Staff understood their safeguarding responsibilities and knew how to report concerns. For example, one staff member told us, "I've never felt the need to raise a concern, but if I did I would go straight to the [registered] manager." Records showed the registered manager had notified CQC and the local safeguarding authority of all relevant safeguarding incidents and had completed prompt and thorough investigations where required.

Requires Improvement

Is the service effective?

Our findings

People's rights and freedom were not always protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

During the care planning process, senior staff had assessed people's capacity to make specific decisions, such as to receive medicines, a modified diet or support with personal care. Where the assessment concluded that the person lacked capacity to make certain decisions, staff acted in people's best interests by making decisions on their behalf and providing appropriate care. However, they did not always document the decisions they had made to show why the decision was in the person's best interests and to confirm that relevant people, such as family members and healthcare professionals, had been consulted. Although this had been done in respect of some decisions for some people, it had not been done consistently or in accordance with the MCA Code of practice. We discussed this with the registered manager who provided an assurance that they would review the relevant care records to ensure best interests decisions were correctly documented in future.

When we spoke with staff, they were clear that they only provided care and support with the consent of the person. A staff member told us, "If people can't make choices, everything we do is done in their best interests. If they decline care, we suggest we will come back later; but if they still say 'No', then it's no; we don't force them." We heard staff seeking verbal consent from people throughout the inspection.

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 DoLS applications had been made where needed and any conditions imposed had been followed. However, there was not a process in place to ensure DoLS authorisations were renewed before they expired and staff were not clear about which people were subject to DoLS. This posed a risk that people could be subject to restrictions not authorised in law. For example, the DoLS authorisation for one person had expired in January 2018 and this had been drawn to the attention of staff by a relevant person's representative in May 2018. However, we found staff had still not re-applied for the DoLS authorisation. The registered manager attributed this failure to an oversight on their part and by the end of the inspection, a renewal application had been made for the person.

People told us staff were competent and provided effective care. A friend of one person told us, "We think [the person] is well cared for and happy here." An advanced nurse practitioner who had regular contact with the home told us, "The care is getting better; I'm impressed with what they [staff] do." A relevant person's representative told us, "In terms of care, I am satisfied with what I've seen. I don't have any concerns and the care notes are always up to date."

Although the staff we spoke with were competent, records showed not all staff were up to date with their training. This posed a risk that their knowledge and practice could be inappropriate or unsafe. The provider's policy required staff to complete refresher training in essential subjects every year. However, we found a nurse who was responsible for taking charge of fire safety procedures in an emergency was overdue fire safety training by four months; their training in safeguarding and infection control was overdue by 12 months and they had not completed training in the control of substances hazardous to health (COSHH) or health and safety since they started work at the home two years previously. The moving and positioning training of a senior care staff member was overdue by nine months and only 10 of the 30 staff who supported people to eat had completed training in food hygiene.

The registered manager acknowledged that staff training was an area for improvement and had started imposing sanctions on staff who failed to attend planned training sessions, in an effort to improve attendance rates. They were also in the process of rolling out the Care Certificate to all staff working at Inglefield, including experienced staff, to promote good practice. The Care Certificate is an identified set of 15 standards that health and social care staff adhere to in their daily working life. It is important for new staff to complete, which all had done as part of their induction, but is also beneficial for other staff. Where this had been completed, we found the training related to the Care Certificate was robust and included observations and discussions about their practice.

Nurses usually demonstrated an evidence based approach to their practice. For example, they used recognised tools to assess people's nutritional needs and their skin integrity. They also demonstrated a sound understanding of bowel and catheter care. However, we found they were not taking a consistent, evidence-based approach to supporting people with diabetes; for example, they were conducting regular blood sugar tests of two people with diabetes without a clinical basis or clear rationale for doing this. We discussed this with the clinical lead nurse who undertook to liaise with people's GPs and specialist nurses to review the frequency of the tests.

Our observations and conversations with care staff showed they had the knowledge needed to provide effective personal care to people and records confirmed people had received this. For example, care files and check sheets confirmed that people had been supported with personal care and been supported to move and reposition in bed when needed.

Staff were appropriately supported in their role. They described managers as "supportive" and "approachable". One staff member told us, "They [managers] always praise you when you've done something right." Another staff member told us managers had been understanding when a family member became very unwell and they needed time off; they said, "They [managers] kept in touch and made me feel supported and appreciated." Staff were also supported through the use of one-to-one sessions of supervision, staff meetings and observations of their practice. The observations for care staff included a robust assessment of their practice against each of the care certificate standards. In addition, staff who had worked at the home for over a year received annual appraisals to assess their performance and any development needs. Some of these were overdue, but the registered manager assured us they were scheduled to be completed in the near future.

People's nutrition and hydration needs were met and people were satisfied with the quality of their meals. Comments included: "The food is good, hot, and plenty of it. I eat it all, I'm not fussy", "The food is fine; it's all fresh" and "The food is very good". One person told us, "I'm not a meat eater and they have no problem with that, they never offer it. The cook often says, 'I've got something for tomorrow that I think you'll like', which is nice."

Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet or needed their meals and drinks prepared in a special way to meet their needs and we saw these were provided consistently. A choice of meals was offered the day before, but people could change their mind at the point of service if they wished. A family member told us "Sometimes my [relative] can't eat the food due to her condition so they will make her something she can manage like scrambled egg or a baked potato." Most people ate in their rooms, either through choice or need. When people required support to eat, this was provided in a dignified way on a one-to-one basis. Staff were attentive to people during meals and made sure people's drinks were topped up throughout the day.

Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. They also monitored people's weight and took action when people started to lose unplanned weight. For example, they sought advice from GPs and supported people to take food supplements where these were prescribed.

Some adaptations had been made to the environment to make it supportive of the people who lived there; for example, handrails had been installed in all corridors, the lighting levels were good and a passenger lift connected the three floors of the building. However, signage was limited and we found it difficult to navigate around the building, as did some of the visiting professionals we spoke with. The registered manager told us of plans to re-arrange the home into colour-coded zones and to make one part more suited to the delivering of palliative care, in which they planned to specialise.

People's health was monitored and they were referred to other healthcare professionals when required. These included doctors, specialist nurses, chiropodists, opticians and dentists. An advanced nurse practitioner who had regular contact with the home told us staff called them appropriately and always followed their advice. People were supported effectively when they are admitted to or discharged from hospital and essential information was transferred with them. This included information about the person's medicines and their care needs and helped ensure continuity of care for people.

Staff made appropriate use of technology to support people. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries. An electronic call bell system allowed people to call for assistance when needed and we were told this would be upgraded to allow data to be analysed. Wi-Fi had also been installed to allow people or their visitors to keep in touch via the internet and to allow staff to access training resources online.

Good

Is the service caring?

Our findings

At our last inspection, in July 2017, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always treated with dignity and respect. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

People consistently told us they were treated in a kind and compassionate way by staff. Comments included: "I like the carers, they are very nice people"; "The staff are caring and seem very nice", "The carers are very good to me" and "I am very happy here; the carers are lovely". A family member echoed these views and said, "The staff here seem very nice; we've no complaints at all."

We observed positive interactions between staff and people living at Inglefield. Staff supported people in a considerate way which people appreciated. For example, after supporting a person to transfer to a chair, one person thanked the staff member and said, "Well done dear, you are very gentle." Where people needed support to eat, we saw staff did this in a patient and dignified way on a one-to-one basis. Staff engaged with people in a positive, supportive way, for example by describing the meal they were offering. If people were asleep at meal times, staff said they would usually wait until the person awoke to offer them their meal. This was confirmed by care records that showed people had received their breakfast at varied times.

Staff used appropriate techniques to communicate effectively with people according to their individual needs. For example, when speaking to people with hearing loss, they faced the person and spoke clearly; when communicating with people living with dementia, they used short, simple phrases and gave the person time to process the information. In addition, written information about the Mental Capacity Act was available to people and their families in an easy-read format, as was the provider's complaints policy.

Staff explored people's cultural and diversity needs during pre-admission assessments and during discussion with the person and their family. Any identified needs were recorded in the person's care plan, usually in the "This is me" section that helped staff understand the person's background and lifestyle. For example, some people chose not to eat meat, for personal reasons, and we saw this was respected.

Staff respected people's beliefs and supported them to follow their faith. A staff member told us how they had read the bible to a person who "had a strong faith" shortly before they were due to have a significant operation and said this had made the person "smile and relax". A minister of religion attended the home every two weeks to conduct a service or to distribute Holy Communion. Another person was of a different faith and with the person's permission staff encouraged people from their community to visit the person often.

Staff encouraged people to be as independent as possible by offering choices and encouraging people to do as much as they could for themsleves. One person told us, "I walk the corridors here several times a day, I need to keep my fitness up." Staff described how they had supported the person to regain their independence following a serious illness. They said, "[The person] wasn't walking when they arrived, but as

they got better we gradually encouraged them to do more. Now you can give [the person] their towels and they can wash and dress themselves. We introduced it slowly at first but now they've got the hang of it and are doing everything." Another staff member said, "When we are getting things ready [to deliver personal care], we encourage people to start undressing. If you give them a nice hot soapy flannel, they can usually wash their own face."

Staff respected people's privacy by knocking and waiting for a response before entering their rooms. When providing personal care, staff described how they closed curtains and doors and kept the person covered as much as possible. A staff member told us, "If the family are there, I like them to leave, but I always ask the resident first. I always stress it's the resident's choice [whether the family stay]."

People and relatives told us they were involved in discussing and making decisions about the care and support they received. For example, a family member said, "[My relative's] records are available for me to see anytime. I've only to ask." Records showed staff consistently involved family members in decisions about their relatives' care and updated them promptly with any changes in their condition.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood their individual care and support needs. One person said, "They help me when I need it." Another person told us, "If I don't have help, it's because I choose not to. They [staff] are led by me."

Staff demonstrated a good awareness of the individual support needs of people living at the home. They knew how each person preferred to receive care and support. They also knew which people needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time.

At the beginning of each shift, a 'handover' meeting was held. We observed one of these meetings and heard people's needs being discussed in a professional, caring way. It was evident that the staff knew people well; for example, during one meeting, we heard staff discussing ways to encourage a person to eat and how the person liked hot buttered toast prepared in a specific way.

People's care plans were comprehensive, reviewed regularly and covered a wide variety of topics, including: the person's normal daily routine, mobility, medicines and personal preferences. However, they did not always support staff to deliver care in an individualised way. For example, one person was known to become very agitated at a certain time of day and during personal care. Their care plan encouraged staff to "be calm in your approach" and "if in a communal area, take [the person] to their room to watch TV quietly". However, it had not identified any effective strategies to support the person when they became agitated in their room, as they did for an extended period on the second day of the inspection. Staff were not able to provide effective support during this time to reduce the person's agitation and did not use any tools to monitor the person's behaviour or identify the triggers and causes of their agitation. Another person was at risk of self-neglect and staff told us they often declined personal care, but a care plan was not in place to guide staff about the action they needed to take when this happened. We brought this to the attention of the registered manager who undertook to develop suitable plans for people with behavioural support needs and by the end of the inspection had obtained specially designed charts to enable staff to monitor people's behaviours more effectively.

Staff expressed a strong commitment to supporting people at the end of their lives to have a comfortable, dignified and pain-free death. Most staff were highly experienced in providing end of life care and described how they worked with doctors and community nurses to support people and their families in a compassionate way. During the inspection, two people had been identified as approaching the end of their lives. We saw they appeared comfortable and staff were managing their symptoms well. However, end of life care plans had not been developed for them, to include information about their end of life wishes and preferences. This posed a risk that things that were important to them might not be known or met, especially by agency staff who would not know them well. We discussed this with the registered manager, who told us they were due to start working towards the 'Gold Standard Framework' for end of life care. Once implemented, this would help ensure that all best practice guidance was followed and that people's end of

life needs were known, recorded and met consistently.

Staff were responsive to people's changing needs. For example, one person told us, "I developed a rash on my legs. Staff expressed concern and said, 'You ought to see a doctor'. [They] gave me cream and I'm smothered in the stuff every day. They've also increased my baths to three times a week, which has helped." A family member told us, "Since [my relative] has been here we have seen a huge change in her for the better. Thanks to the staff and management, she is much more awake and aware. She's putting on weight and is more lively. [Previously] I couldn't touch her as she was so anxious; now I can hold her hand and she seems sometimes to know me."

People had access to a range of activities based on their individual interests; these included arts, crafts and external entertainers. One person told us, "We have activities here Monday to Friday. I go downstairs to join in, it's nice to get out of my room." A family member told us, "[My relative] played bingo yesterday and won twice; she enjoyed that." The activity room was used for a communion service on one of the days we visited and hosted bingo on another of the days. A visit by donkeys from a local sanctuary was planned for the day following our inspection and was eagerly awaited by the people we spoke with. In addition, records showed one-to-one activities had been arranged for people who were unable to, or who chose not to take part in group activities.

People told us they felt able to raise concerns or complaints, although most said they had not had cause to complain. A complaints procedure was in place and was displayed on the home's notice board in an accessible format. A family member told us, "Any concerns I've had have been resolved. For example, a stand aid was broken and they got it fixed." We viewed records of recent complaints and saw these had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. For example, a complaint about the care received by one person had been resolved to the person's satisfaction and the staff member concerned had undertaken 'reflective practice' to consider and reflect on the impact of their actions.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, in July 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service. At this inspection, we found action had been taken and there was no longer a breach of this regulation; however, further improvement was still required.

New quality assurance systems had been implemented since the last inspection. These included a range of audits conducted by senior staff and recently introduced 'provider audits' by an independent auditor on behalf of the provider. We viewed the first of these that had been completed shortly before the inspection; it was comprehensive, thorough and had identified a range of improvements that were needed. These included most of the areas of concern that we had identified during this inspection and had led to the development of an action plan, which once completed will bring about the necessary improvement. The audits had not identified the failure to complete pre-employment checks consistently and the lateness of some appraisals, although the registered manager to address these issues during the inspection. This showed the quality assurance systems needed further development and time to become fully effective and embedded in practice.

The provider's system for reviewing people's care plans relied on these being done by named nurses on a monthly basis. We saw this had not happened consistently; some areas of people's care plans had not been reviewed since April 2018, leading to the information becoming out of date, for example in respect of a person's DoLS status. The independent auditor had reviewed one person's care plan and identified this and other concerns within that care plan. The registered manager told us other care plans would be subject to similar scrutiny. Once this process is fully established, it would help ensure people's care plans remained up to date.

There was an open and transparent culture where visitors were welcomed. One person told us, "My [relative] comes in every day which is nice; the carers are very welcoming." A family member told us, "I can come and go as I please and am always made welcome." The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently on the home's notice board and on the provider's website. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The registered manager showed us examples of where this had been followed, even though the threshold for taking action had not been reached. In a case where the threshold had been reached, the registered manager had provided all the necessary information to a family member verbally, but had not followed this up in writing, as required. After discussion, the registered manager undertook to ensure this was done in future and the general manager offered to source a suitable template for this purpose.

People and their relatives told us they were generally satisfied with the way the service was run. For example, one person said, "I've never been in a home before, but it seems well organised. It's a happy house." A family member told us, "We are moderately satisfied [with the service]. I'd say have a good shop

around; I wouldn't rush to recommend it, but [my relative] needed nursing care, so we had little choice [in the area]." An advanced nurse practitioner, who had regular contact with the home, told us they would be happy to place a loved one at Inglefield, if they needed nursing care.

People were consulted in a range of ways about the way the service was run. These included occasional 'residents' meetings', questionnaire surveys and individual discussions with people and their relatives. This had led to changes in some of the activities that were organised. In addition, a sample group of people had been invited to review proposed new menus and their feedback had been incorporated into the menus.

The registered manager was fairly new to the role, having been registered with CQC in March 2018. They told us they had found the role "challenging" due to the departure of the deputy manager, which had created extra workload; and the loss of the lead nurse, which had left the service without a clinical lead. However, appointments had recently been made to both of these roles and an advanced nurse practitioner, who had regular contact with the home, told us the appointees were "brilliant" and had already brought about improvement in the clinical support staff received.

The registered manager told us they felt support by the provider's general manager, who visited often and was always available for telephone advice. The registered manager had completed a training programme, funded by the local authority, aimed at supporting managers to improve standards in care provision and this had provided them with a broad network of support.

Staff communicated effectively between themselves to ensure people's current needs were known and met. They told us they were happy and motivated in their work and described managers as "approachable", "good" and "wonderful". Comments included: "I've been here for some time, I like it here, it's a good place to work", "I can always go to [one of the managers] and am definitely listened to. They will try and resolve any problems" and "I feel supported and am comfortable knocking on the manager's door, she is approachable".

The registered manager was taking action to reduce the level of staff sickness and the consequent use of agency staff. They had enhanced the sickness monitoring arrangements and worked with staff to identify more suitable shift patterns and enable them to book holiday further in advance. They told us this had reduced the levels of staff sickness and enhanced morale.

The provider was still developing a set of values for staff to follow. In the meantime, the senior staff member responsible for organising staff training told us they were trying to promote a shared understanding of the purpose of the service and encourage positive values amongst the staff. For example, they described how they had run dignity workshops and had used the observations recorded in our last inspection report as a basis for discussion. This demonstrated a willingness to learn from mistakes and had led to the more compassionate culture that we witnessed at this inspection. Further learning had occurred in relation to a person who was receiving shared care from Inglefield staff and staff from a domiciliary care agency. Following some initial difficulties, the registered manager told us they had recognised the need for clearer lines of responsibilities and for their own staff to keep more comprehensive records.