Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24, 25, 29 January 2018 and was unannounced. At the last inspection, we found the service was in breach of regulations. We found the service was not meeting the regulations to provide person centred care plans and not investigating and responding to complaints in a timely way. We also issued warning notices for the lack of sufficient staff and mealtime provision. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well-led to at least good. This inspection was undertaken in order to check how the provider had met its action plan. We had also received information of concern from an external source prior to this inspection and these concerns were looked into as part of the inspection. This is the fourth time this service has been inspected and rated as requires improvement.

The Wingfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Wingfield is a care home with nursing registered to provide personal and nursing care for up to 89 older people. The Wingfield is part of Barchester Healthcare Homes Limited. The service is housed in two separate buildings a short walk from each other on a site that is shared with a GP surgery and pharmacy. The smaller building, The Lodge has accommodation for up to 32 people on three floors. The second building, Memory Lane has accommodation on two floors for up to 57 people, and specialises in providing care to people living with dementia. At the time of our inspection, there were 19 people living at The Lodge and 41 people living in Memory Lane.

There was a registered manager in post. 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.

Staff were not recruited safely, references from previous employers were not always verified and checked and where issues were identified, the service had not followed up to check discrepancies. Where potential issues had been identified and disclosed by the applicant risk assessments had not been put in place to make sure people were being supported by suitable workers.

Safeguarding concerns had been raised about four members of staff. The provider had taken the decision not to suspend all of them pending an investigation. Where this decision had been made there were no risk assessments in place to safeguard people whilst an investigation took place.

There were areas in the service, which due to their poor condition could not be cleaned effectively. The areas we highlighted as in need of maintenance are not part of the refurbishment programme.

People told us they felt safe and were cared for by staff who were kind and caring. We observed positive social interactions during our inspection, which demonstrated that staff knew the people they were supporting well.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Where people had their liberty restricted, the service had completed the related assessments and decisions had been properly taken. Staff had been trained and understood the general requirements of the Mental Capacity Act (2005).

People's medicines were managed safely. We observed medicines were administered safely and in line with the provider's policy. Safe storage and disposal arrangements were in place. Nurses administered medicines and had appropriate training to make sure they remained competent.

Staff were trained in a number of areas to support them to undertake their duties effectively. Staff had regular formal supervision and told us they currently felt well supported. Staff felt they could approach the registered manager with any concerns.

Management of complaints had improved, we found they were investigated and responded to within the timescales of the provider's policy. Lessons learned were shared with staff via staff meetings, which were held regularly.

Care plans reflected people's current needs and were reviewed regularly. Where needed monitoring records were completed in full and checked daily by nursing staff.

People were supported to eat sufficient food and drink. Meals were well presented and there was a choice of menu. Staff were available to support people to eat and drink, as there were sufficient numbers of staff on duty.

People could pursue their interests, as there were dedicated activity workers who planned activities with people. Activities were evaluated regularly to measure engagement.

We found one breach of Regulations; you can see what action we told the provider to take at the back of the full version of the 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 always safe.

Recruitment was not always robust. References were not always sought from the necessary people and not followed up where potential issues may be indicated with regard to character or practice.

Safeguarding concerns had been raised about four members of staff, there were no risk assessments in place to make sure people were safe.

There were areas of the service, which could not be cleaned thoroughly due to worn paintwork or cracks in flooring.

Staffing levels and deployment had improved and was consistently sufficient to meet the needs of people.

Accidents and incidents were recorded and analysed.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills and knowledge to meet their needs. Staff were well supported by the management at the service.

The service was working within the principles of the Mental Capacity Act and demonstrated this with the appropriate assessments and best interest meetings where appropriate.

People had sufficient food and drink; mealtimes were relaxed and supported by staff who knew people's preferences. Records of food and drink were kept accurately where a need was identified.

People had timely access to healthcare professionals where

needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and were aware of individual needs. They responded appropriately and timely to requests for help and support.

People's information was held securely and only accessed by people who had authority to do so.

People were encouraged to personalise their rooms and bring in their own belongings and small items of furniture.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and well written to give staff guidance on how people's needs would be met. People's wishes regarding their end of life care were documented.

Reviews were held regularly and involved people and relatives where appropriate.

Activities had improved and were provided based on people's preferences. Workers regularly evaluated participation and reviewed provision based on people's engagement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Whilst quality monitoring was in place and effective for some areas, it had not identified issues with recruitment. Risk assessments had not been put in place for staff where concerns were identified about their practice.

There was a temporary registered manager in post who was stabilising the service until a permanent manager could be found. This meant the service had been without a permanent manager since 2015.

People's views were sought and evaluated to improve the service. Quality monitoring was completed by a range of people and shared with staff.

The service was trying to extend their community links and making efforts to invite people into the service.

The Wingfield

Detailed findings

Background to this inspection

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

This inspection took place on 24, 25 and 29 January 2018 and was unannounced. The inspection was carried out by three 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. Their experience in this inspection was nursing homes and people with dementia.

Before our inspection visit, we reviewed the information we held about the service. We looked at information within the statutory notifications the provider had sent to us. A statutory notification is information about important events, which the provider is required to send us by law. We reviewed information about the service from the local authority who commission services and the local Health watch. Health watch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also reviewed information the provider had sent us about how they were going to address our concerns from the last inspection. We had received information about poor recruitment practices from an external source. We used this information to plan what areas we were going to focus on during our inspection visit.

Some of the people who lived at the home were not able to tell us about how they were cared for because of their complex needs. However, during our inspection we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us.

We spoke to the registered manager, deputy manager, three nurses, eight members of staff, 10 people, four relatives and one visiting healthcare professional. We reviewed 12 recruitment files, six care and support

plans, medicines records, maintenance records and other records relating to the management of the service.

Requires Improvement

Our findings

At our last inspection in June 2017, we rated this key question as requires improvement with an identified breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 for insufficient staff deployed. We issued the provider a warning notice. Whilst the provider had taken steps to improve this area at this inspection, we found other areas that required improvement. We inspected records for 10 staff some of whom had been recently recruited. The service had completed Disclosure and Baring Service (DBS) checks for all staff. A DBS check allows employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. DBS checks were reviewed with all staff every three years. The provider had also checked that nurses employed in the home had a valid registration with the Nursing and Midwifery Council. However, the provider had not always made safe decisions when checking references from previous employers.

We found one staff file which did not have the required reference from their previous employer. The member of staff had not stated their reason for leaving their previous employment and we found that the provider had not explored this during interview, there were no interview notes available to review. We saw another member of staff who had received a reference from their previous employment which alerted the service that they had disciplinary action on their file. This had not been explored prior to employment. Another member of staff had recently been recruited and started work, their previous employer had declined to give a reference, this action had not been explored by the service. The provider has informed us that one member of staff has been dismissed since our inspection due to their application information. Where any concern was identified during the recruitment process there were no risk assessments on file to make sure measures were in place to keep people safe.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

Staff we spoke to had the knowledge and confidence to identify any safeguarding concern and report their concern to the registered manager. Staff we spoke to told us they had received safeguarding training and the training records confirmed this. Staff were aware that they could take concerns to external agencies if they felt action was not being taken by the service. Where staff had reported members of staff for potential poor practice this had been referred to the local authority safeguarding team. When decisions had been made by the provider not to suspend the members of staff we found there was no risk assessment in place to make sure people were safe pending an investigation. We raised this with the deputy manager at the time of our inspection. Since our inspection we have attended a safeguarding meeting with the provider and the

local authority safeguarding team to discuss these concerns.

We observed staff using personal protective equipment such as gloves and aprons when needed. The service completed monthly infection prevention and control audits to monitor systems and safe practice. The service had robust cleaning schedules and was clean in all areas with no odours detected during our inspection in any area. However, some areas of the service were tired and in need of repair. For example we found in the laundry area the flooring around the washing machines was cracked in places and peeling from the wall. The window sill next to the washing machines was exposed to the wood as the paint had peeled off. Floors in toilets and bathrooms required review as some were cracked and in need of renewal. We saw the sealant in one toilet around the sink pedestal was peeling off, in another toilet the sealant around the toilet was discoloured and peeling. In one bathroom a wooden cover over pipes was exposed to the wood in one patch. The exposed absorbent surfaces in these areas meant it was not possible to clean them effectively and increased the risk of cross infection. All the toilets at the service had wooden toilet seats. We observed that some were cracked or worn so that the surface was absorbent. We raised these issues with the registered manager at our inspection. The infection prevention and control audits had identified this issue so plans were being produced to address the concern. Since our inspection the service had taken steps to replace all the wooden toilet seats.

Staffing levels had improved consistently. We observed the service had provided consistent levels of staff on day and night shifts. The people, staff and relatives we spoke to confirmed this. One member of staff on Memory Lane felt that there were enough care staff to meet people's needs. They told us, "It's much better now we have the staff. There are always five care assistants and sometimes we have six." One relative we spoke to told us they felt their relative's needs were being met, as there were enough staff to keep people in Memory Lane safe.

The deputy manager said that they were responsible for producing the nursing and care staff rosters in the home. This had previously been the responsibility of individual unit managers. They said that they felt this had improved the management of staffing levels. We observed there was an activity worker present in the lounge at The Lodge. A relative told us, "Now there is normally a care worker in the lounge, that did not used to happen, that was difficult." People and their relatives told us they felt safe. One relative told us, "I feel my [relative] is safe here." Another relative told us, "When [relative] first came here, I would not have been sure who to speak to if concerned, now I can talk to staff."

Medicines were managed safely. Registered nurses were responsible for the administration of medicines. The deputy manager said that nurses undertook medicine management training both with Barchester and with the pharmacy provider. They then undertook practical competency tests annually. We observed a registered nurse on part of a medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to and their practice was seen to be safe. They wore a 'do not disturb' tabard whilst administering medicines.

Medicines were stored safely. In Memory Lane, people had their own container within a medicines trolley. This meant all medicines belonging to one person were kept together. In The Lodge, people's medicines were stored in individual secure cabinets in their rooms. The temperatures of the rooms, storage rooms and medicine fridges were recorded daily. Those seen were within acceptable limits. Controlled drugs (CD) were kept securely and their administration was recorded in an appropriate CD register. Two signatures were evident for each administration. Stock checks were undertaken. We checked the stock levels of two controlled medicines, which were found to be correct.

Medicines administration records (MAR) we reviewed had people's photographs along with details of

allergies and how they preferred to take their medicines. A selection of MAR sheets reviewed showed no gaps in administration records. Appropriate codes were used for non-administration and details of why were recorded. Where handwritten amendments were added to MAR sheets, two signatures were seen. Protocols were available for 'as required' (PRN) medicines. A homely remedy protocol that had been signed by a GP was seen.

There was a system in place for the recording of prescribed topical medicines, such as creams and lotions. Topical medicine application recording sheets containing body maps were kept in a folder in the person's room. Care assistants were expected to sign these following applications of the topical medicine. Those seen had been fully completed apart from one gap on one chart.

Three people living on Memory Lane required the use of a prescribed thickening agent in their drinks due to problems swallowing. Information from a speech and language therapist relating to the consistency required was detailed in their care plans. Staff members were provided with information about the consistency of drinks the people required on handover sheets. The thickening agent was securely stored and comprehensive information relating to the texture of food and consistency of drinks was on display in the kitchenette adjacent to the dining room.

The service had robust risk assessments for the environment and a programme of maintenance, which included safety checks. These checks included a weekly test of the fire system, passenger lift checks, water testing for legionella and visual checks on wheelchairs. There were service records for equipment such as hoists, which demonstrated that appropriate servicing and checks were made routinely. Where any fault was detected equipment was put out of action and repaired or replaced.

People had individual risk assessments in their care and support plans where needed. This included an assessment of risk in areas such as mobility, choking, nutrition and pressure ulcer prevention. Where risk had been identified, people had risk management plans in place. If people had episodes of distress and expressed this with behaviour that caused concerns the service sought appropriate support and guidance. The mental health team were approached and asked to visit to offer guidance on care and support plans. The unit leader on Memory Lane was a dementia champion and supported the staff team to develop their skills and knowledge when supporting people living with dementia.

If people were not able to use their call bell there was a risk assessment on their file to make sure they were kept safe. Staff we spoke to were aware of the safety measures to follow for these people, which included extra visits to their rooms to check they were safe. One relative told us, "Staff call in regularly to see [relative], they don't use their bell but they come and check on her." We observed that some people had sensor mats by their beds or chairs to alert staff that people had moved. We checked people's files and saw that they had care plans and risk assessments for these interventions. We spoke to the unit manager who told us some people had sensor mats in place as they were high risk of falls.

The home recorded accidents and incidents. The management reviewed these forms and analysed them for trends or indications of ill health. Any findings were shared with staff at team meetings or during the 'daily stand up meeting' with senior staff. We reviewed the records from the staff meetings and observed discussions had taken place to review practice around falls, medicines incidents and development of pressure ulcers. Improvement measures were discussed and plans were put in place to prevent re-occurrences.

Safeguarding referrals had been made to the local authority safeguarding team where needed. The service had taken some remedial action. The registered manager had completed an unannounced night visit in

response to a concern raised. They told us there were lessons to be learned from this visit and had already shared these lessons with the senior team via the 'daily stand up meeting'.

Good

Our findings

At the last inspection we found the service required improvement to make sure people had the support, they needed to eat and to keep accurate records of what people had or had not eaten. At this inspection, we found the service had made the required improvement. We observed mealtimes on both days of the inspection and found people had the choice of where they wanted to eat their meal and choice from a range of options. People with dementia were offered a visual choice of meal; plates were presented to them so they could see the options and smell them. Those people who chose to eat in their rooms were served promptly and the meals appeared hot and well proportioned. Those who required support to eat were supported by staff individually and were given time to eat at their own pace. There was a relaxed atmosphere in the dining room. A host served the meals and all of the care staff, a nurse and a member of the activity team helped with the meal provision.

People told us "Food is good, not very good but good." Another person told us, "Food is good, choice of two meals." Another person said, "I always have a choice and they offer tea and coffee between meals." One relative told us, "They employ hospitality staff to help with meals which is good, at one stage they took away those hours which put pressure on the care staff." Another relative said, "There is a good choice of food, if you don't like it they will make you an omelette."

People had care plans relating to nutrition and were assessed each month in order to see if they were at risk of malnutrition. Food and fluid charts seen had been fully completed and had been signed and reviewed by staff each day. Fluid charts had daily intake targets specified and had been totalled each day. Those seen indicated that people were receiving adequate food and drink.
We observed people were offered drinks throughout the day. Some needed support from staff to be able to drink. We observed staff knelt down or sat down by people to offer support. The support offered was gentle and caring and encouragement was given for people to drink.

Each person had a pre-admission assessment, which had been completed by management or a nurse. The assessment identified what people's needs were and established that the service was able to meet people's needs. Care plans had been produced based on the pre-admission assessment and covered a range of needs such as personal hygiene, pain management, tissue viability and nutrition.

People received care from staff that had the skills and knowledge to meet their needs. We saw that newer staff had a comprehensive induction, which included completion of the care certificate. They also worked alongside more experienced staff for a period of time, which enabled the service to assess their suitability

and competency during their probation period. The registered manager kept a training matrix so they could see at a glance who needed what training. Staff had received training for a number of areas such as moving and handling, first aid, food hygiene and dementia care.

Nursing staff received training and updates to refresh their nursing practice in clinical areas such as wound management, tissue viability and urinary catheterisation. Reliance on agency nurses had dropped which meant people were being nursed by staff who knew them and their needs consistently. The deputy manager told us since they commenced their role in 2017 they had taken management activity off the nurses which meant that "The nurses are now free to nurse." One nurse told us about the impact of using less agency staff. They felt that they now had more time to do their role, as previously they had to spend a lot of their time making sure agency staff knew important information about people. Staff shared information about people daily in a handover. There was also a 'daily stand up meeting' for senior staff to get together and discuss key events such as admissions, discharges, complaints and social events.

Staff told us they received regular formal supervision and felt well supported. There was a supervision matrix available in the registered manager's office, which enabled the management to keep track of who needed a formal supervision. Staff we spoke to told us that support had improved over the past six months and they now felt they could approach the registered manager with their concerns.

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 be as least restrictive as possible. Staff we spoke to understood the principles of the Act and we observed that people were encouraged to make decisions about their care and treatment. Where people lacked capacity, we saw the service had worked within the principles of the MCA. Two people were receiving their medicines covertly. Both had a 'record of decision to administer medicines covertly' in the MAR folders. These indicated that the decisions had been discussed with a GP and pharmacist and with a person who had power of attorney for health and welfare.

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 and hospitals 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 made applications appropriately to the local authority, where they had been authorised the service was meeting the conditions. A number of applications were waiting to be processed, the deputy manager was keeping these under review.

People had access to healthcare professionals. One relative told us their relative was able to keep their own GP when they moved to the service, which was a comfort. During our inspection, we observed a GP was visiting people. They confirmed that nursing staff referred people to them promptly when needed, but added that they thought they were also good at having measures already in place in order to prevent any potential crises. A visiting GP said of a unit manager on Memory Lane "[Name] is excellent, she really knows the people very well. This can be a difficult place to manage, but I think they do really well." They added, "I have no concerns about the people living here. I think they are very good at getting people to settle in."

One person we reviewed had been admitted with pressure sores. Their care plan stated that they needed to be provided with an air mattress to be set at an inflation pressure of '4', which equated to the persons weight. They also needed their position changed 'every 2 to 4 hours'. We saw that the air mattress was in

place and had been set at the correct inflation pressure. Repositioning records for the week prior to the inspection were reviewed and found to be fully complete, indicating that the person's position had been changed at least every four hours. The person had records relating to the treatment of their wounds and had been seen by a tissue viability nurse specialist. Records indicated that the wounds had improved in the time the person had been in the home.

Records of visits by, and contact with, various health care professionals were recorded in people's care plans. Those seen included general practitioners, nurse specialists, speech and language therapists, consultant psychiatrists and members of the community mental health team.

The Wingfield was purpose built as a nursing home. The home had communal space including dining areas and lounges as well as spacious rooms with en-suite facilities. Corridors and doorways were wide so that a wheelchair could easily access all areas. Memory Lane had some adaptions to support people living with dementia but there was more that could be done. Toilet doors were a contrasting colour from the walls, which helped them to stand out when walking down the corridors. There were textured wall hangings on the walls, which people could engage with as they walked around. There was secure garden space so people could enjoy the outdoors in safety. However, some areas were in need of redecoration, which the registered manager had identified. At the Lodge we saw that people's names were on the doors to their rooms, some were written on a white sticker. The registered manager told us this had been identified as an improvement so they had already ordered new signs. They also showed us their plans for refurbishment of some corridors and communal areas in Memory Lane.

Good

Our findings

At our last inspection, we found this key question required improvement, at this inspection we found that improvement had been made. People were being supported and cared for by staff who knew them and responded to their needs. Staff we spoke to were knowledgeable about people's needs and respectful of differences.

One person told us, "Staff help me get up, I can do some of it myself. I can get up when I choose." Another person told us, "Look around you we are all clean." One person told us that they always found the staff to be "nice and kind". We observed that staff treated people with kindness and compassion. They spoke to people with respect and used their preferred names. One person told us, "The care staff are nice to me." One relative told us, "Carers here are very kind, nice, thoughtful and knowledgeable." They added, "They are now encouraged to sit and talk to people."

Personal care was carried out in a way that promoted dignity and independence. One person told us, "It is mostly the same staff looking after me." Another person said, "all the staff are female so not an issue about who cares for me, I would not want a man." We saw that people had a choice of gender documented in their care plans. Where people had stated they would only want personal care from female staff this was documented and staff we spoke to were aware of who had stated a preference. One relative told us, "Staff talk to [relative] whilst they are supporting them, they don't talk across him to each other." One member of staff told us, "I always think how would I feel in their position, how would I want care delivered to me." They told us this helped them deliver care that was respectful and always mindful of people's dignity. They went on to say, "During personal care I make sure people are covered at all times so they never feel exposed, I want them to feel safe."

Choice was promoted throughout the service and we saw evidence of this in many areas. One relative told us, "They do my [relative's] personal care but give him choice, if he chooses not to be shaved that is respected." People could choose where they wished to spend their time during the day and whether they wanted to join in planned activities or not. People's privacy was respected. We observed staff knocking on people's doors and waiting to be invited in. People's confidential information was treated with respect and kept securely. Handovers between staff were held in offices with the door shut so that personal information was not overheard.

Where people experienced distress, this was responded to with kindness and an understanding of people's feelings. We observed one person who became distressed when their relatives finished their visit and left.

This person was new to the service. The staff were calm and reassuring, they walked alongside the person listened to them and stayed with them until the person felt more reassured. We observed another occasion where a person was becoming increasingly anxious during their mealtime. They were supported to move to a different area of the dining room where they could look out of the window. The member of staff supported this person discreetly, without undue fuss so the person maintained their dignity. This move decreased their anxiety and they could eat the remainder of their meal contently.

People were encouraged to maintain relationships that were important to them. There were no restrictions on visiting hours, relatives were encouraged to come to the service and eat with their relative if they wished. One relative told us, "I have no complaints about the care, morale has vastly improved in the last six months. Staff now seem to enjoy what they are doing and feel secure." Another relative told us, "Staff always make me feel welcome, they offer me food and drinks."

We saw people had personalised their rooms and had brought in items that were important to them such as chairs, pictures and photographs. One person told us, "I have brought things in, mainly small things like photos and pictures rather than furniture." Another person told us, "I like my room, I have my things." People felt their belongings were treated with respect. One person told us, "They take my clothes and it comes back the next day. I always get it all back, my daughter labelled it all."

The registered manager told us that if people needed an advocate this could be sourced locally. Information on advocacy services were available in the home.

Good

Our findings

At our last inspection, we found this key question required improvement. We found care plans were not of a consistently good quality and people were not supported to follow their interests. We found at this inspection the required improvement had been made and this key question is now rated as good.

Improvements had been made to the provision of activity at the service. We spoke to the activity worker who told us they felt activity provision had been improved both with group activity and 1-1 personalised activity. They told us they were supported by the registered manager and the deputy manager who were both keen to improve the activities provided. Representatives from local churches visited the service twice per month to enable people to practice their chosen faiths. Community groups, musical entertainers and children from the school next door to the service visited to sing and entertain people.

During the inspection we observed a group of people with advanced dementia participate in a sensory activity in the sensory room. People appeared to be engaged with the activity and were relaxed. We also observed a 'Knit and natter' group activity, not everyone joined in the knitting but it was a social activity and we observed the activity worker trying to involve everyone present in the 'natter'. A visiting hairdresser was available to anyone living at the service. Staff also provided 'pamper sessions' for people if they wished, one person told us, "We have pamper sessions when staff do our nails, we choose our colours."

People were consulted about the activities provided at the service and had opportunities to be involved in planning. We observed activity plans were visible in all areas of the home and everyone had one in their room. The activity worker kept records of all activity and evaluated how successful they were in terms of engagement and enjoyment. They had found activity involving animals had been most successful recently. One relative told us, "They are hoping to develop some gardening activities which would please my [relative] as they were a keen gardener." Feedback we received about the activity workers was positive from both people and their relatives.

People received care and support that was responsive to their needs. The care plans we reviewed gave sufficient information on the individual needs of people. Peoples care plans contained assessments and support plans relating to needs such as nutrition, moving and handling, continence, tissue viability, hopes and concerns for the future and social activity. Care plans had been regularly reviewed and care was personalised.

One person had been assessed as being at very high risk of developing pressure sores. Their care plan stated

that they required a pressure relieving air mattress on their bed and needed to be repositioned every four hours. Records indicated that the person felt more comfortable on a Triflex non-air mattress and we saw that this had been provided. Records of four hourly positional changes were seen and found to be fully completed. A risk assessment relating to the use of a Triflex mattress had been completed and the care plan stated that should the person's tissue viability decline, then an air mattress should be provided. The person did not have any pressure sores.

There was personalised detail about people identifying both physical and emotional needs. We observed that one person had experienced a stroke, which had left one arm weak. The person used this arm most frequently so this caused them anxiety. This need had been identified and measures put in place to support them to try to reduce their episodes of anxiety. People's communication needs were recorded in their communication support plans. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We observed that where people had speech, hearing or vision impairment this was identified and detail was recorded about how this would affect the person's communication abilities.

People had been involved in writing their care plans. Where this was not possible relatives that had the appropriate consent had been asked to be involved. One relative told us, "I was part of writing the care plan, her capacity is variable."

Care plans were in place that recorded people's wishes and preferences for care and support at the end of their lives. Important information such as people's religious needs or whether they wished to go into hospital or remain at home were clearly documented. Staff we spoke to were aware of individual's end of life choices. Records in the care plan of a person who was nearing the end of their life stated their wishes that no active interventions were to be taken to prolong their life. They had been reviewed regularly by their GP and records seen, allied to the comments of staff, indicated that they had been kept comfortable and pain free. They passed away with their next of kin holding their hand, which a staff member stated was their wish.

One person who was living with dementia and who was new to the home, had exhibited behaviours that were challenging to staff. Records evidenced that staff had been prompt in involving the person's GP and members of the community mental health team, including a consultant psychiatrist. A review of the person's medicines had been carried out and the person's behaviour was recorded and reviewed on a behaviour chart in order to look for trends or triggers. Staff were observed monitoring and supporting the person, without being too obtrusive.

People had files in their rooms that held information on positional changes, food and fluid intake and topical medicine administration. On the front of the files there were quick reference guides to the person's needs and preferences. These listed personal hygiene needs, how I eat, how I drink, favourite drink, sleeping, communicating, aids, things that worry or upset me, what makes me feel better, routines that are important to me, things that I don't like and things I like. The details recorded were personalised. For example on one file it was written, 'I can become upset during personal care but I tend to respond well to distraction techniques such as singing and general chit chat.'

Complaints and concerns were listened to and responded as per the provider's complaints policy. Detailed records were kept of each complaint, how it was investigated and the outcome. We saw the registered manager had started holding a 'manager surgery'. This was held every Tuesday evening and gave relatives the opportunity to meet with the manager and discuss any concerns they may have.

Requires Improvement

Our findings

At our last inspection, we rated this key question as requires improvement. At this inspection we found that not all the necessary improvement had been completed. We found a number of shortfalls in the way the service had recruited staff. This indicated that although there was a quality monitoring programme in place it was not robust in identifying omissions within the recruitment procedure. Infection prevention and control audits completed had identified the concerns we found in toilets and bathrooms regarding re-decoration and refurbishment. There was no plan available to record when the service will complete these works. Quality monitoring systems were in place and were effective at identifying improvement in a range of clinical areas. The deputy manager said that they had undertaken clinical audits in relation to care planning and medicine management. They said it was the responsibility of nurses and senior care staff to audit intervention charts, such as food and fluids, positional changes and topical medicine administration, on a daily basis, but that they also did random checks to ensure compliance.

The service had been without a stable registered manager since 2015. At this inspection, we found that the service did have a registered manager in place; they became registered in January 2018 but had been working at the service for the previous six months. They had stabilised the service and improved morale for the staff. The registered manager was employed by the provider as an operations manager and will only stay at the service until a new registered manager is found and recruited.

There was a sense from everyone at the service during our inspection that the service had improved in the last six months. One relative talked about how the service had been "shocking" and they were very worried. They said they were "relaxing" now. People and their relatives we spoke to recognised that the new registered manager had brought changes and things were much better. One relative told us, "We did not know where the problem was, there was a series of different managers, were they being treated badly?" Another relative told us, "The current regime told us they have no difficulty getting resources but we were told previously they had to adhere to staffing levels."

A member of staff told us, "The manager listens to us and has put a lot in place. It's good here now." A nurse said, "Things have improved, It's more stable. We have enough staff and stable management. We are there now." A Unit Manager said, "We are much, much better here now; it's more like the old Wingfield." A visiting GP said, "There was a blip due to staff changes but I feel they are over that now."

Whilst people, relatives and staff are more confident with the leadership of this service there was an uncertainty about what will happen in the future. We saw staff interacting with the registered manager and

asking them to stay permanently. The service had recruited a new deputy manager in 2017 and it was recognised by staff and relatives that they had also contributed to stabilising the service. The deputy manager was mostly based in The Lodge. One relative told us, "It is good the deputy is over here [The Lodge] as I can catch her." Relatives we spoke to expressed concern about what will happen once the current registered manager leaves. One relative told us that they felt the current manager was good but they worried as they knew they were interim. One relative told us, "I have three years' experience of being at this home, I am still feeling the need to be super vigilant." One member of staff told us, "The current manager really supports us, it would be good for them to stay." A permanent general manager would reassure people, relatives and staff that the improvements that had been made would continue.

The service tried to maintain links with the local community. The service had started a scheme called 'Don't dine alone'. Posters had been delivered to the local community to encourage older people to come into the service for a meal at lunchtime. The registered manager told us so far this offer had been taken up by relatives but they hoped it would grow.

Resident and relatives meetings were held regularly and minutes kept. One person told us, "There are residents meetings, if I had an issue I would talk to the manager." One relative told us, "We talked about food in the residents meeting and raised the issue that the fancy names can be confusing for people, they are going to look into this." People's feedback was sought in a range of areas. The most recent survey was a food survey, which the registered manager shared with the kitchen staff. One relative told us, "Food can be variable, the new catering manager is very much needed."

There was a sense from people, their relatives and staff that the culture in the service had changed for the better. There was a relaxed atmosphere during our inspection, all areas of the service felt calm and unhurried. One relative told us, "All the staff are now good at talking with the relatives, if the maintenance man comes in he explains what he is doing and talks to us, the cleaners are also good at this. The current culture has encouraged all staff to spend time talking, not just the care staff, all of them." One member of staff told us, "Things have remarkably improved here, staffing levels have improved which means everything has improved, the atmosphere is less stressful." They went on to tell us, "I was looking for another job, but I am not now as the culture here is now positive."

The service worked in partnership with other agencies such as commissioners of services and health care organisations to support people. It is a requirement that the service displays the rating from the previous inspection; we saw this was displayed at the service and on the provider's website.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider did not have robust recruitment procedures in place to ensure that staff employed were of suitable character and had the necessary competence, skills and experience needed to carry out their duties safely and effectively.