Buckland Care Limited

Inglefield Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Inglefield Nursing and Residential Home is registered to accommodate up to 49 people who require nursing or personal care. At the time of the inspection, 44 people were living at the home.

The inspection was conducted on 12 and 13 July 2017 and was unannounced. There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At out last inspection, in October 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe infection control procedures were not always followed; medicines were not always managed safely; and environmental risks were not always managed effectively. At this inspection we found action had been taken, although some further improvement was still needed.

Infection control procedures had improved and all areas of the home were clean. However, not all staff were up to date with their infection control training and some did not use individual hoist slings when supporting people to transfer; this posed a risk of cross infection.

Most individual and environmental risks to people were managed effectively. However, on one of the inspection days, staff took six minutes to locate specialist equipment which might have been needed in an emergency; and a known trip hazard in a person's room had not been addressed. In addition, measures taken to reduce the risk of people developing pressure injuries had not been recorded to ensure staff followed them consistently.

An extensive programme of audits was conducted by the registered manager and a representative of the provider. However, these had not always been effective in bringing about improvement.

People's dietary needs were met and they praised the quality of the meals, although we found the mealtimes were rushed and staff did not always show consideration for people they were supporting to eat. Some staff talked amongst themselves while others used inappropriate terminology when talking about people. However, other staff interacted positively with people.

Staff took a task-focused approach to the delivery of some aspects of people's care and people told us their preferences were not always met, such as the time they went to bed. We have made a recommendation about this.

People told us they received effective nursing and personal care. Induction procedures for new staff were robust; however, some staff had not completed refresher training in essential subjects such as food hygiene

and fire safety.

Staff told us they were supported in their work by managers and had one-to-one sessions of supervision, although only four had received an appraisal of their performance in the past year.

Care plans were reviewed regularly and provided comprehensive information to enable staff to meet people's essential care and support needs. However, one person's care plan lacked information about the support they needed when they became agitated.

A limited range of activities was provided, although these were not always well attended and were still being developed to meet people's individual interests.

There were usually enough staff to meet people's essential needs, although some people felt staff were rushed.

Safe recruitment procedures were followed to help ensure only suitable staff were employed. However, appropriate checks had not been completed for a volunteer who supported people with activities.

Staff protected people from the risk of abuse and the registered manager conducted thorough investigations into allegations of abuse.

People received their medicines as prescribed from staff who were suitably trained. They were supported to access other healthcare services when needed.

People's rights and freedom were protected in line with legislation. They were involved in planning their care and support; and their privacy was protected while personal care was being delivered. At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death.

The provider sought and acted on feedback from people. People knew how to complain about the service and the registered manager conducted thorough investigations into all complaints.

There was a clear management structure in place. Staff were organised, understood their roles and worked well as a team. They told us Inglefield was a "happy place to work".

There was an open and transparent culture. Visitors were welcomed at any time; CQC were notified of all significant events; the home's previous rating was displayed prominently; and staff enjoyed positive working relationships with other health and social care professionals.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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.

Not all staff had attended refresher training in infection control. Some staff did not use individual hoist slings for people which posed a risk of cross infection.

Most risks were managed effectively. However, a known trip hazard for one person had not been addressed and measures taken to reduce the risk of pressure injuries had not been recorded to ensure they were followed consistently.

There were usually enough staff deployed to meet people's needs and staff responded promptly to people's call bells. Robust recruitment processes were followed to check the suitability of staff, although these checks had not been followed for a volunteer who supported people with activities.

People felt safe at Inglefield and staff knew how to identify, prevent and report incidents of abuse.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had completed the provider's refresher training to ensure their knowledge remained up to date. However, induction procedures for new staff were robust.

Most staff had not received an annual appraisal to assess their performance, although they had attended individual sessions of supervision and said they felt supported in their role.

People's dietary needs were met. However, people did not always have a positive mealtime experience as service was rushed and some people were not supported in a dignified way.

Staff followed legislation designed to protect their rights and freedom. People were supported to access other healthcare

services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with consideration and respect. However, some people told us staff were kind and caring.

Staff protected people's privacy while delivering personal care. They encouraged people to remain as independent as possible and involved them in decisions about their care.

At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff took a task-focused approach to some elements of people's care and people said choice was sometimes limited.

Most care plans were well organised and provided comprehensive information about people's needs. However, one person's care plan lacked essential information about the support they needed during personal care.

A limited range of activities was provided, but these had not been tailored to meet people's individual interests.

The provider sought and acted on feedback from people. People knew how to complain about the service and all complaints were thoroughly investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

An extensive programme of audits was conducted by the registered manager and a representative of the provider. However, these were not always effective in bringing about improvement.

There was a clear management structure in place. Staff were organised, understood their roles and worked well as a team.

There was an open and transparent culture. Visitors were made welcome at any time; CQC were notified of all significant events

and the registered manager was proactive in reporting concerns to partner agencies.

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 was 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 12 and 13 July 2017 and was unannounced. It was conducted by an inspector, a specialist advisor with a background in nursing 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, we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection, we spoke with 11 people living at the home and three visiting family members. We also spoke with the registered manager, the clinical lead nurse, three registered nurses, a support nurse, the head of care, four care staff, an activities coordinator, two cleaners and a chef. We looked at care plans and associated records for 11 people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records. We also received feedback from a community nurse who had regular contact with the home.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in October 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe infection control procedures were not always followed; medicines were not always managed safely; and environmental risks were not always managed effectively. At this inspection we found action had been taken and there was no longer a breach of this regulation, although further improvement was still needed.

The provider had appropriate infection control policies and procedures in place and the home was visibly clean. One person told us, "The place is immaculate; the cleaners are very thorough." Staff had access to disposable gloves and aprons throughout the home and were clear about the arrangements for processing soiled linen. The laundry room had been re-organised to help reduce the risk of cross infection. Infection control risk assessments and cleaning schedules had been developed. Check sheets confirmed that all cleaning had been completed in accordance with the cleaning schedules, together with regular deep-cleans of people's rooms.

The provider's policy required all staff to receive refresher training in infection control every year to help maintain their knowledge; however, records showed that less than half of the staff had completed this training in the past 12 months. This posed a risk that infection control standards could slip. For example, we found that although staff used individual slide sheets to support people to reposition in bed, some staff shared hoist slings between people when supporting them to transfer between bed, chairs and commodes. This posed a risk of cross infection; when we identified the issue to the registered manager, they took immediate steps to address it and showed us dates that had been set for additional sessions of infection control training.

Individual risks to people were not always managed effectively and a specialist machine was not readily available to staff if needed. For example, some people were at risk of choking on their food; risk assessments had been completed and advice from speech and language specialists had been sought. One person received some of their food through a percutaneous endoscopic gastrostomy (PEG) which is a tube that allows food and medicines to be given directly into the stomach; however, they had asked to continue to receive some food orally. The person had full capacity and was aware of the risks involved, but had chosen to accept them. To reduce the risk as much as possible, the registered manager had made a decision that only registered nurses would support the person with their oral meals and we saw this was followed. The service had two suction machines that could be used to in an emergency, if the person started choking; however, on the first day of the inspection it took six minutes for one to be found. This could have had serious consequences in the event of an emergency. On the second day of the inspection, staff were able to access the suction machines immediately. Staff told us they checked the machines daily, although there were no records available to confirm this. We discussed this with the registered manager, who put measures in place to ensure records were kept of all checks performed.

Another person was at risk of falls. Records showed they had fallen twice on the day before the inspection. One fall occurred when the person tripped over trailing cables in their room; on the second day of the

inspection we saw the trailing cables were still in place, putting the person at risk of further falls. Staff told us the person was safe walking up and down a corridor adjacent to their room on the top floor of the building and said the person "knew not to use the stairs", or a ramp to a lower floor, as they wouldn't be safe. However, on the second day of the inspection the person self-mobilised to a lower floor. A falls prevention plan had not been developed for the person and the risks of them using stairs and ramps not been assessed. We discussed this with the registered manager who took immediate action to remove the trip hazard from their room and undertook to complete a risk assessment and falls care plan for the person.

The registered manager monitored accidents, incidents and falls across the home on a monthly and yearly basis to identify patterns or trends. This had recently identified two people who had experienced multiple falls for whom care plans and risk assessments were in the process of being reviewed and developed. One person told us, "They put new flooring on the en-suite [in my room] because I kept slipping, I didn't think they would be able to do it, but they put down a non- slip floor." Another person had experienced a fall which caused a head injury. The registered nurses had conducted hourly neurological observations for a 24 hour period, in accordance with the provider's policy, to assess whether any internal injury had been caused. However, this was not fully in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE) which recommends more frequent observations initially, becoming less frequent as time progressed (assuming no untoward symptoms were detected). The registered manager told us they would review their policy to bring it into line with NICE guidance.

The risks of people developing pressure injuries were being managed appropriately. The level of people's risk had been assessed using a nationally recognised tool. Where the tool identified that people were at high risk of pressure injury, measures were taken to reduce the level of risk; for example, people who were being nursed in bed were given special pressure-relieving mattresses and were being turned regularly; there was also a process in place to help ensure the mattresses stayed at the right setting according to the person's weight. One person receiving such care told us, "I am well looked after, yes certainly." However, the need for special mattresses and regular turns was not always recorded in people's care plans to help ensure staff took a consistent approach. We discussed this with the registered manager, who undertook to document the preventative measures that should be taken to ensure they were followed consistently by staff. When pressure injuries started to develop, staff took prompt and appropriate action to treat the person and used photographs to monitor their progress. They also had access to a skin integrity specialist if further advice was needed.

Other environmental risks were managed safely. A steep ramp that had been present at our last inspection had been removed; the corridors had been de-cluttered to provide clearer access in the event of a fire; the home's fire safety risk assessment had been reviewed, which had led to the installation of an extra fire door, and fire safety checks were conducted regularly. Staff were clear about the action to take in the event of a fire and people had personal emergency evacuation plans in place. These detailed the specific support each person would need if the building had to be evacuated. An automatic external defibrillator (AED) had been installed since the last inspection and all registered nurses had attended training to use it. They had also been trained to deliver first aid.

There were usually enough staff deployed to meet people's needs, although people had mixed views about this. Negative comments from people included: "They're frequently short staffed; they don't cater for [staff sickness]. They say 'We can't do this and that because we're short staffed"; "They are so busy; they run about like scalded cats"; and "They could do with some more staff as they seem to be run ragged, especially at night". More positive comments included: "You may have to wait a few minutes, but 98-99% of the time you press the buzzer and [staff are] here in two to three minutes. If they can't come straight away they come and say 'you'll have to wait for a few minutes'"; and "They always come promptly when I need them, like for the

commode in the night."

Although some people felt more staff were needed, none was able to give any examples of how the perceived shortages had affected them directly. The registered manager told us they based the staff levels on the Barthel index (a tool used to assess people's ability to take part in "the activities of daily living", such as washing and eating). They monitored the staffing levels by auditing call bell response times. These showed around 95% of calls were answered in less than five minutes.

People told us there had been a shortage of staff on the night shift between the two days of our inspection as two care staff members had reported sick. This left one registered nurse and two care staff to support 43 people. The registered manager acknowledged that staffing levels had fallen below the minimum that were needed on this night, but said this was an isolated incident due to staff reporting sick at short notice. They had tried to call in off-duty staff and had contacted a staffing agency for support, but had been unsuccessful due to the short notice.

Robust recruitment processes were in place to check the suitability of staff before they were employed by the service. Staff records included an application form, full employment history, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. For registered nurses, checks were also conducted to confirm that they were registered with the Nursing and Midwifery Council (NMC) to practice. The service used a volunteer to support people with activities once a week. Although the volunteer was usually supervised, they sometimes supported people on a one-to-one basis on their own. They had not been subject to a DBS check but, when we identified the issue, the registered manager undertook to do this immediately.

People told us they felt safe at the home. One person said, "When I came in, it was all-embracing, like they [staff] were saying 'you're safe now, we'll look after you, everything's going to be alright'; and it has been." A family member told us, "I can go away and think '[my relative] is being taken care of'."

Staff had all received safeguarding training and described how they would identify, prevent and report incidents of abuse. Their knowledge was also checked during observations of their practice by managers. Records showed that when safeguarding concerns were raised, the registered manager conducted thorough investigations and liaised closely with other statutory agencies to keep people safe, including the local safeguarding authority.

People were supported to receive their medicines safely. There were appropriate arrangements in place for obtaining, storing, administering and disposing of medicines. One person told us they got their medicines "on the dot; morning, midday and evening". Medicines were administered by a registered nurse or by a support nurse under the authority and supervision of a registered nurse. They were given during regular medicine rounds and according to need; for example, one person needed one of their medicines at 5:00am and other people needed medicine on an 'as required' (PRN) basis, which records confirmed they received.

Medicines administration records (MAR) for oral medicines were fully completed. The MAR charts used to record the application of topical creams were also fully completed and there was an effective process in place to help ensure topical creams were not used beyond their 'use by' date. Medicines that needed to be stored at cool temperatures, in accordance with the manufacturers' guidance were kept in a medicines fridge. The fridge had just been replaced as the previous one had not been working effectively.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective nursing and personal care. One person said, "There's proper 24 hour nursing care and that's what I need. You can call [staff] night and day." A family member told us, "What [my relative] gets here is continuity. There's the same team of nurses and she knows them all, especially the [staff] who come round with the pills."

'The provider was unable to assure themselves that staff had the right skills and knowledge to support people effectively. The provider's policy required staff to complete refresher training in essential subjects on a yearly basis. However, not all staff had completed this training. This posed a risk that their knowledge and practice could become out of date. For example, records showed that only 4% of staff who supported people with meals had completed refresher training in basic food hygiene; only 17% of staff had completed refresher training in health and safety; and only 55% of staff had completed refresher training in fire safety. The registered manager told us they received positive feedback from staff attending the training, but acknowledged there was "a high level of non-attendance". In an effort to improve, they had started imposing sanctions on staff who failed to attend planned training sessions.

However, our observations and conversations with staff showed that most had the knowledge needed to provide effective 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 bowel care, had been offered food and drinks, and had been supported to move and reposition in bed when needed.

We found induction procedures for new staff were robust. New staff were allocated a mentor for support and care staff who had not worked in care before were supported to complete the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. As part of this, they spent time working alongside a more experienced member of staff before having their competence assessed through knowledge checks and observations of their practice. A staff member told us, "I had a big induction. I had to go through all the policies and procedures, for example, fire safety, health and safety, infection control. It was quite detailed and [a senior staff member] checks what we are doing. She tells us if we've done something wrong and if we've done well." Registered nurses and support nurses attended additional training relevant to their roles. This included blood sugar monitoring, pressure area care and medicines management.

The provider required each staff member to receive a yearly appraisal to assess their performance. However, the registered manager told us they had only completed four appraisals in the past year as staff were "not turning up" for scheduled appraisal meetings. They acknowledged this was an area for improvement and had set new dates for people's appraisals.

Although staff had not received appraisals, they all told us they felt supported in their role by the registered manager and had received sessions of supervision to discuss progress in their work and other matters relating to the provision of care to people. Staff told us they found these meetings useful. One staff member said, "I feel very supported. I can go to the manager to discuss any concerns." Another told us, "I've been

given the support I need to do my job, been offered extra training and can go to the managers for advice any time."

People's dietary needs were met and they praised the quality of the meals. One person told us, "It's well-cooked, good food". Another said "The food's wonderful. I had cooked breakfasts every day for a week [when I arrived] and was putting on too much weight, so I've had to cut back." A family member echoed these comments and told us "The meals are nicely presented and seem quite good."

Although people were satisfied with the quality of the meals, we observed that the meal time experience was not always positive for people. All meals were served at the same time, throughout the home, so the service was rushed. It was a task that seemed to cause high levels of stress amongst the staff and one they appeared keen to complete with undue haste. Whilst some hot desserts were kept in a food warmer, others were given to people at the same time as their main course which meant they were cold by the time they came to eat them. One person told us, "I'm happy to eat it cold as I've got used to it; but I suppose out of preference I would rather have it warm."

People said they could request alternatives if they did not want anything from the menu. One person told us, "You can opt for something else. I don't like fish, so they offer me a salad." Another person said, "There are usually three things on the menu. I'm allergic to [certain foods] and they will always substitute them. They will always do a ham omelette; they are very accommodating." Some people needed their meals pureed and their drinks thickened to make them easier to swallow and staff were clear about how to do this in line with recommendations made by speech and language therapists.

People who were being nursed in bed received appropriate support to eat and drink. Drinks were within reach of people who could drink independently. People who needed help to drink were offered drinks at least every hour throughout the day. Records of the amount people ate and drank were maintained and prompt action was taken if people's intake declined or they started to lose unplanned weight. For example, they were given larger portions, their meals were fortified with extra calories and they were offered additional snacks. Where necessary, people had also been referred to their GP, so food supplements could be prescribed.

Some people needed full support to eat and drink. Some staff provided this in a dignified way, on a one-to-one basis; they engaged with the person and described the food they were offering. However, other staff did not do this consistently. While supporting a person to eat in the dining room, on the first day of the inspection, a staff member was called away as they were about to start supporting them. Without any explanation to the person being supported, they put a lid over the person's food and left. After five minutes, a staff member who had been supporting a second person, in a neighbouring chair, to eat stopped supporting that person and starting supporting the first person with their meal. They did this while standing over the person and alternated their support between the two people. Before either person had finished their main course, this staff member left to fetch their desserts, again without any explanation. They returned with the hot desserts which were left to go cold while they continued supporting the two people to finish their main courses. On the second day of the inspection, two people were supported on a one-to-one basis in the dining room; however, there was limited communication to support them to understand what they were eating. A third person in the dining room, who also needed support to eat, was left for 40 minutes before being given their meal, without any reassurance or explanation.

We shared our observations with the registered manager who undertook to review the way meals were served and people were supported to eat.

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA). The 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.

Following an assessment that followed the principles of the MCA, some people had been assessed as lacking the capacity to make specific decisions. During the care planning process, senior staff had, therefore, made decisions on their behalf and documented why the decisions were in the person's best interests. These included decisions relating to the care and support people received, the use of bed rails and the administration of their medicines. Family members had been consulted and their views had been taken into account. Where people had capacity to make decisions, this was recorded in their care files on 'consent forms', which people had signed to show their agreement with the care and support that was being delivered.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. A DoLS authorisation had been granted for one person and further applications were being processed by the local authority. Conditions had been placed on the DoLS authorisation and there were clear records to show that these had been followed by staff.

People were supported to access other healthcare services when needed. A family member told us, "When [my relative] was unwell they [staff] checked everything and then phoned and got a doctor." There was a weekly GP or nurse consultant round to discuss people's medical needs. Records showed people were also seen regularly by other specialists, opticians, dentists and chiropodists. The home was piloting a 'Telehealth' scheme in partnership with a local GP surgery. This allowed staff to monitor people's health using handheld computers and to transfer the data electronically to the surgery for analysis. This had helped diagnose conditions and led to earlier medical interventions for people.

Requires Improvement

Is the service caring?

Our findings

Most people who were able to express their views told us staff were kind and caring. Comments included: "The staff are all lovely"; "The staff are lovely. They are all very polite. They can't do enough for you"; "The staff are very kind and they all get on well"; and "They couldn't be more caring". A community nurse who had regular contact with the home told us staff provided "lovely care" to people.

However, we found people were not always treated with dignity and respect. One person told us, "It would be better to get a spot more [dignity and respect]. They [staff] are very busy in themselves rather than in the person they've come to serve. They tend to talk amongst themselves rather than to the person they've come to serve. It's natural, they're friends and they tend to have a lot to say to each other; but they're not really focused on you and I can feel sometimes they could attend to you more." This person's comments reflected our observations, which showed staff were not always attentive to people and did not always treat them with consideration.

For example, one person used a wheeled chair. Staff told us the person struggled to communicate verbally, but had "some understanding" of what was happening and could express themselves through their body language. On two occasions, we observed different staff members approach the person in the dining room and wheel them out of the room without any conversation or explanation. On the second occasion, the person had been watching a visiting musician; staff later told us they had taken the person to a support group meeting relevant to their condition. Although the staff felt the person would have benefitted from attending the meeting, they had not offered them a choice or supported them to express a view about this.

On two other occasions, when staff were supporting people to eat in the dining room, we observed that they did not engage with the person, but spoke over them to engage in conversation between themselves about their social lives. This showed a lack of respect and consideration for the people they were supporting. At other times, we heard staff using inappropriate language, for example referring to people as "feeds" and over-using terms of endearment such as "darling" and "love" repeatedly. On one occasion, a staff member said to another, "I can't wake up that lady over there; she's blotto and hasn't had her pudding yet." The comment was made in the dining room and would have been heard by other people and again showed a lack of respect for the person.

The failure to consistently treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, other interactions we observed between people and staff were more positive, friendly and respectful. For example, when a person became disorientated, a staff member took them by the arm, quietly reassured them and led them back to their room. When another person started singing, a staff member joined in. Another staff member was taking time to clean the room of a person who had recently died; they said, "The family will be coming to collect [the person's] belongings and it's important it looks nice for them as that's what they'll remember." This showed sensitivity and understanding. Two people used communication devices to spell out words. Staff were clear that it was important to give the person time to

complete their sentences and to communicate at their pace, even though it was a slow process.

People told us their privacy was maintained during personal care. One person told us, "They [staff] always knock before they come in. They are polite and helpful." We saw that staff took care to make sure toilet and bathroom doors were closed when they were in use, and put signs on people's doors so the person would not be disturbed during personal care. Staff also described other practical steps they took to protect people's privacy, including keeping the person covered as much as possible and explaining what they were about to do. People said they could choose the gender of the staff who supported them with personal care. One person said, "I can choose male or female [staff]. I don't mind either, except I draw the line when it comes to washing me. I don't want men for that, I only have the girls."

Care plans included a section entitled: "All about me" which included details of the person's background, their life, people important to them, their preferences and wishes. When we spoke with staff, we found they knew people well; they could tell us the person's former occupation, the names of their children who visited, their interests, needs and preferences.

People were encouraged to remain as independent as possible within their abilities. Their care plans include advice to staff to allow the person to do as much as possible for themselves, such as only washing areas they could reach and staff were clear about how they promoted independence. For example, they had commissioned a local specialist to make a bespoke call bell for a person with a degenerative condition, who was not able to use a standard call bell. This had enabled the person to have more control over the support they received and the time they received it.

People and, when appropriate, their relatives were involved in discussions about their care and treatment. Family members confirmed they were always kept up to date with any changes to the health of their relatives. Entries in people's care files showed this process was ongoing; they included records of conversations with family members and comments made by them during reviews of the person's care.

People received appropriate end of life care. We reviewed the care records for two people who had recently received end of life care at the home. These showed that at the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death. Information about people's preferences for their end of life care was included within care files. Nursing and care staff had attended training to enable them to support people appropriately at the end of their lives. The registered nurses were aware of who they could contact for additional support if required and we saw palliative care specialists were often involved. The registered nurses were aware of how to obtain and administer symptom management medicines should these be required; where necessary, these medicines were held within the home so they would be immediately available should the need arise. Staff liaised with the GP if they thought people were approaching the end of their lives to ensure they were seen within two weeks of the anticipated time to reduce the need for post mortem examinations. The registered nurses had also attended training in the verification of death which avoided distressing delays in post-death procedures for family members. Other staff had visited a local crematorium as part of a training programme to make them more aware of what happens after death, so they could provide more effective support to family members.

Requires Improvement

Is the service responsive?

Our findings

Most people told us staff understood their needs and said their essential needs were met. However, we found staff had a task-focused approach to some elements of providing people's care as they had little time to interact and support people in a personalised way. One person told us they were supported to have a bath every week, but this was not always a positive experience. They said, "[Staff are] not good at attending to you and paying attention when you're in the bathroom". They added, "It would be very good, if they were good at it, to have [baths] twice a week." They explained that they had not asked for more baths as they were not supported in the way they preferred. Another person told us they could not always choose when to go to bed. They said, "You have to go to bed at a certain time. I start going at 9:00pm and get there at 10:00pm. You can't really watch something on TV at 9:00pm because that's going to be bed time. When I was first here I used to go later and they [staff] didn't seem to mind; but now they want us to go to bed earlier." A family member told us, "Sometimes [my relative] is put to bed early. Sometimes between four and five o'clock. I came once and she was in bed at 4.00pm. I don't know why she was in bed."

Assessments of people's care needs were completed by one of the managers before people moved to the home. This information was then used to develop appropriate care plans, in conjunction with the person. People's care plans were well organised and provided comprehensive information to enable staff to meet most people's essential care and support needs. However, records showed that one person often declined personal care or became agitated while it was being delivered. Staff told us they only supported the person in pairs, to reduce the risks to themselves and the person, and recorded all interactions. Some told us of tactics they found helped calm the person, for example talking about specific family members, but other staff were not aware of this and there was no information in the person's care plan to guide them. We raised this with the registered manager, who said they would develop a "behaviour support plan" for the person to help ensure all staff supported the person in an effective and consistent way.

We recommend the provider reviews the way people's care is planned and delivered, to ensure it meets people's individual needs and reflects their preferences.

Check sheets and entries in people's care records confirmed that most people's essential needs were met consistently. For example, some people had catheters. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters are prone to blockages and infections if good fluid throughput is not maintained. People's fluid intake and output were monitored, using the check sheets, and there were clear plans in place to help ensure catheters were maintained properly. There were also clear plans in place to support people with diabetes. Staff monitored people's blood sugar levels to check they remained within a safe range; they administered insulin or medicines when needed and kept a stock of emergency medicine to treat people whose blood sugar levels had fallen below a safe level.

Each person had a named nurse who took particular responsibility for ensuring their needs were met. The named nurse also reviewed the person's care plans every month to help ensure they reflected the person's current needs. Care records also showed that the named nurse updated family members when any changes in the person's needs or health status were identified.

Arrangements were in place for staff to share information about people's health status and current needs. Two 'handover' meetings were held at the beginning of each shift; one for the nursing staff and one for the care staff. These included information about bowel monitoring, pressure area care and nutritional intake for each person and identified people who needed extra support or monitoring. Nursing and care staff also communicated and liaised with one another throughout the day to discuss people's needs.

A range of activities was provided for people by activity coordinators, although these were limited to around three hours on each weekday and they had not been tailored to meet people's individual interests, as recorded in their care plans. One person told us, "On Mondays they have a quiz and on Tuesdays they don't have anything because the hairdresser comes. They go out for picnics, I like those. I'd like more activities like handicrafts and exercises. There's music and movement, but it's not organised. You just wave your arms and legs about, it's not professionally led." Another person said, "There's a good programme of events, but they don't suit everyone." A further person described the activities as "a bit dull".

Staff had formed an 'activities committee' to discuss and organise events for people. They had arranged a Christmas party where they had put on a pantomime for people; they were also organising a summer fun day and a float to take part in the local carnival. People were not represented on the activities committee because staff told us "It's something we like to do for people." However, people were consulted about general activity provision during 'happy hour' meetings that were held every month.

A minister of religion attended the home each month to conduct a service. People told us they enjoyed this. On the second day of the inspection, a musician visited to entertain people; however, only four people attended the session as there was a Stroke Association support group running at the same time, which other people had chosen to attend. An activity coordinator told us they spent time on a one-to-one basis with people who were being nursed in beds; however, activity records showed people had declined this more often than they had accepted it, indicating the activities offered were not in line with their interests.

The registered manager acknowledged that activity provision was still being developed as people's activity needs had changed following the recent introduction of people needing residential care rather than nursing care.

The provider sought feedback from people, relatives, staff and external professionals including through the use of questionnaire surveys and 'happy hour' meetings. People said they felt listened to. One person told us, "I just talk to [the head of care]. Last week she got me a bigger fan. You just have to ask her and she'll sort it." Another person said, "They got me a new carpet, a darker one. I chose it; they brought round the sample books to show me." We also saw that changes had been made to the menu, following feedback from people.

People knew how to complain or make comments about the service and the complaints procedure was displayed in the entrance hall. Relatives and people told us they had not had reason to complain, but would contact a senior staff member if needed. The registered manager maintained clear records of complaints. These included any concerns that were brought to their attention from any source. Each concern had been thoroughly investigated and the people involved updated promptly with the outcome.

Requires Improvement

Is the service well-led?

Our findings

People told us the service was organised and said they would recommend it to others. One person said, "I only came for respite for three days, but after everything was done for me, I said, 'Can I stay?' So now I'm here for good."

An extensive programme of audits was conducted by the registered manager throughout the year, focusing on key aspects of the service, such as care planning, medicines, health and safety and infection control. However, the audits were not always effective in bringing about improvement. For example, an infection control audit in May 2017 had not identified the risks posed by people sharing hoist slings. The training outcomes audit in May 2017 had identified a low level of attendance at staff training, but the issue had not been resolved. The staff conduct and performance audit in June 2017 had identified that appraisals were overdue but this had not been addressed. The staff conduct and performance audit included checks to assess whether staff communicated with people in a respectful way. Our observations showed that staff did not always do this, although the audit indicated that, when observed by managers, they did. The observations by managers had, therefore, not been effective in identifying these concerns.

A representative of the provider visited the home each week to support the registered manager and to conduct other audits of the service. The most recent audit, conducted in June 2017 was only partly completed. It monitored Disclosure and Barring Service (DBS) checks for staff, but had not considered the need for DBS checks for volunteers who worked with people. It did not look at staff training or appraisals as the registered manager was "not available" at the time of the audit. It identified that the activity programme did not "support individual abilities and choice" but had not set an action plan to address this.

Reviews of care plans were conducted monthly by senior staff, but these had not identified the lack of a care plan to support a person who became agitated during personal care; they had not identified the lack of a risk assessment for a person at risk of falls; they had not identified that head injury monitoring was not being completed in line with best practice guidance and they had not identified the lack of information about the measures needed to reduce the risk of people developing pressure injuries.

The failure to operate effective systems to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the audit systems did identify other improvement actions, including the need to chase up the delivery of a new medicines fridge; the need for a risk assessment for a person at risk of choking; and the need to review the routine use of certain topical creams. All these actions had been completed.

The provider operated a number of other homes and had processes in place to share information and best practice between their services. For example, following a choking incident at another home, we saw additional guidance had been issued to staff at the provider's other homes to reduce the risks to people. Staff at Inglefield were aware of this guidance and had implemented it fully. The registered manager was an

active member of the local nursing homes association and area managers' network, which helped them keep up to date with developments in the sector.

There was a clear management structure in place, comprising the registered manager, clinical lead nurse and head of care. Registered nurses were responsible for running each shift in conjunction with a care staff team leader. Care staff were deployed to specific areas of the home and were clear about their roles and responsibilities to help ensure people were supported appropriately throughout the home.

Staff were organised, understood their roles and worked well as a team. They told us they enjoyed working at the home and spoke positively about the support they received from management on a day to day basis. They described the registered manager as "supportive" and "approachable". One staff member told us, "It's a happy place to work, everyone is nice. [The registered manager] is approachable and easy to talk to." Regular staff meetings were held to share information with staff and enable them to provide feedback about the service. Staff submitted items for the agenda through a suggestion box and records of the meetings confirmed that all items were fully considered and discussed.

The registered manager told us the standard of care delivery was helped by a low level of turnover of registered nurses; they had not had to recruit a registered nurse for over a year. This meant people received care and treatment from a consistent team of registered nurses who understood their needs well. There had been a higher turnover of care staff, but the impact on this was limited as the senior care staff team had work at the service for an extended period and shared this knowledge with the care staff.

There was an open and transparent culture at the home. Visitors were made welcome at any time and could stay as long as they wished. The previous inspection rating was prominently displayed in the home and on the provider's website. There was a duty of candour policy in place which required staff to act in an open way when people came to harm and the registered manager provided an example of when this was used appropriately.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. The registered manager proactively contacted the local safeguarding team to report concerns that had been brought to their attention. They completed prompt investigations into allegations of neglect or abuse and notified CQC of all relevant incidents in line with the requirements of their registration.

Staff enjoyed good working relationships with other health and social care professionals and had developed positive links with the community to the benefit of people. These included representatives from local churches who attended monthly; a volunteer who supported people with one-to-one activities weekly; schools and scout groups that attended to sing carols at Christmas; and a community bus service that could be used to take people on trips.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that staff treated people with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service.