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Polefield Nursing Home

Inspection report

Polefield Nursing Home
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20 April 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on 18 and 20 April 2016 and was unannounced. We also made a return visit on the 4 May 2016 to check the provider had taken immediate actions to the concerns we raised.

Polefield Nursing Home is a service providing accommodation and support with personal care to a maximum of 40 people who may require nursing or residential care. The home is over two floors and has a passenger lift. There were four rooms on each floor which are double occupancy rooms. There is a communal lounge and dining room on each floor. The home is set back off a main road, with level access grounds. There is a large garden area which people can access. At the time of our inspection, 31 people were living at the service, 13 on the nursing floor and 18 on the residential floor.

The service did not have a registered manager as they had left a few weeks prior to the inspection. The provider intended to register as manager, but at the time of the inspection had not yet begun to undertake this role. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspecting again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate in any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

People felt safe and supported by the care staff. However, not all safety checks had been completed, meaning people were at risk from harm.

Staff sought consent from people before providing care or support. The ability of people to make decisions was not always assessed in line with legal requirements to ensure their liberty was not restricted unlawfully. Decisions were not always taken in the best interests of people when necessary as bed rails were being used without completing assessments on the person's capacity.

Risk assessments were not always up to date. Care plans were not written with the person or their families. People had not been supported to be involved in identifying their support needs. Pre-assessments included people's likes and preferences and staff knew the people well.

Medicines were not always administered safely. We saw evidence staff signing before the medicines had been administered and medicines being potted up and left on the top of the trolley for a period of time before being administered which could result in them being given to the wrong person.

People were well cared for but there were not enough staff to support them effectively. The staff were knowledgeable about the needs of the people and knew how to spot signs of abuse. There recruitment process was not robust sufficient checks had not been implemented prior to staff commencing work.

Staff had not completed training appropriate to their role. Staff were observed as being kind and caring, and treated people with dignity and respect. They spoke to people with respect. There was an open, trusting relationship between the people and staff, which showed that staff knew people well.

People were not always supported to access activities within the home; those who were cared for in their beds lacked social interaction and meaningful activates. People were able to make choices about how they spent their time and where they went each day.

We saw people and their relatives had been asked for feedback about the service they received but there was no record of what actions had been taken to address any identified concerns. Staff did not always work well as a team as those working on the nursing floor did not always feel supported by the nurse on duty. There was an open and transparent culture which was promoted amongst the staff team.

Policies and procedures were out of date and were not being followed. Quality assurance checks had not been completed since 2014 and when incidents had occurred no apparent actions had been taken.

We identified breaches 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?

Inadequate

The service was not safe.

Not all aspects of people's care and support needs had been risk assessed. Risk assessments had not been completed for the environment such as Legionella and fire safety.

Medicines were not always managed safely. Medicines were signed for in advance of being administered.

Clinical and general waste was not stored correctly, until it was collected. Staff were not adhering to infection control policies and procedures.

Staff recruitment was not robust and there were not sufficient staff numbers to meet the current needs of the people living at Polefield nursing home.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments were not always carried out

Staff training in all areas was not up to date.

Referrals were made to health care professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not aware of people who were on end of life care.

Staff were kind and caring to people and treated them with dignity and respect.

People's care was person-centred and their privacy maintained.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were generic and not person-centred. Care plans were not always reviewed and changes not always documented appropriately.

The complaints procedure being displayed in the service was out of date.

Activities at the service were available Monday to Friday but did not meet the needs of all of the people as they were not well attended and those being cared for in bed were not supported to attend.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance checks and audits had not been completed since 2014, and no action taken to address this. We found environmental risk which posed a serious risk of harm to people living at Polefield Nursing Home.

Staff did not feel supported by the nursing staff and there was a lack of clear leadership.

Residents' meetings and staff meetings were not regular and there was

Polefield Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to 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 18 and 20 April 2016 and the first day was unannounced, the second day was by arrangement. We also visited on the 4 May 2016 to check the actions the provider had said that they would take immediately, had been completed. The inspection team consisted of one inspector and a specialist adviser who was a registered nurse and had extensive experience.

Before the inspection, we reviewed the information that we held about the service including any notifications. A notification is information about important events which the service is required to send us by law.

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. The SOFI was carried out on both the nursing floor and residential floor.

We spoke with six people living in the home, a relative, the provider, two registered nurses, six care staff, two members of the domestic housekeeping team, the maintenance operative and a member of kitchen staff. We observed the way people were supported in communal areas and looked at records relating to the service. These included six care records, five staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

This was the first inspection for this service since the provider became registered with us, in November 2015.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at Polefield Nursing Home. When asked, one person told us, "Yeah, I feel safe here". Another person said, "I feel safe". A relative said, "I think [name of person] is safe, with regards to falls."

Although people told us they felt safe, we found risks to people had not always been assessed and managed safely. Risk assessments had been completed but were generalised and did not show the risks to each individual person. We found risk assessments had not always been reviewed and we found that they had not always been updated. For example; one person's bathing risk assessment had not been updated since June 2014. This meant staff did not have up to date information about the person and their current support needs which could result in causing harm to the person and staff.

We found there were no risk assessments or safe systems of practice available for staff to follow in relation to areas such as fire safety, moving and handling of inanimate objects, safe use of kitchen and laundry equipment. The personal emergency evacuations plans (PEEPS), lacked detailed information about each person's support needs and abilities and there was no separate file containing the PEEPS, which staff could access easily in the event of an emergency such as a fire. This could put both staff and people at risk from injury or harm as the emergency service personnel would not have details about each person and how they may react in the event of having to evacuate people from the building.

We found that none of the radiators had covers on them , and on the day of inspection, were incredibly hot to the point you could not touch them. Pipes were exposed and again too hot to touch. Should a person fall against or grab one of these to steady themselves, they would have been at risk from harm. Freestanding wardrobes were not attached to walls and were at risk of falling over particularly if used as an aid from falling.. Due to the number of people living at Polefield Nursing Home, who were at high risk of falls, this was a serious risk. We saw broken light switches and plug sockets which could put people at risk from electrocution. We also saw missing ceiling tiles with insulation hanging down. We informed the provider of these concerns who ensured the ones we identified had been fixed by the end of the inspection. However, the provider failed to then check all other switches and sockets in the home.

We identified a number of trip hazards within the home, one being a pressure mat which was taped down in front of an unlocked door which led to a flight of stairs. A pressure mat alarms when it is stepped on. This was being used to notify staff should any person living at Polefield Nursing Home, try and enter the stairwell. However, we observed a person who lived at the home step over the mat and access the stairwell. This in itself posed a risk as staff would be unaware that this person was there and could have fallen down the stairs. We found that there was no pressure mat in front of the other unlocked door leading to the other staircase at the other end of the home, so it was unclear as to why this particular piece of equipment was in place. We raised this concern with the provider who said it would be removed immediately and magnetic alarms installed. We returned on the 4 May 2016, and found the pressure mat had been removed, but the provider had failed to install the magnetic alarms as stated in the action plan which they had produced following our first two days of inspection, meaning people living on the residential floor were still exposed to

the risk.

We found there were no risk assessments in place for the use of bed rails. We saw that bed bumpers were not being used with the bed rails, this meant people could be at risk from entrapment.
We found the service was carrying out environmental risk assessments such as gas, electric and temperature checks on the water system, but we saw no record that this was being completed in rooms which were no longer being used, but still posed a risk. For example, some of the bedrooms which were currently unoccupied and also some of the old bathrooms which didn't appear to be in use as they housed equipment. We also found that the last external Legionella certificate had expired in August 2015. The meant that the service was not carrying out sufficient checks on the water system to prevent people from coming to harm.

The failure to ensure appropriate risk assessments had been completed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found infection control processes put people's health and welfare at risk. We saw the clinical waste area was not secured or covered. Waste bins were overflowing and we saw used personal protective equipment (PPE) (gloves and aprons), discarded on the ground around the bins. There was evidence of vermin in the waste storage area. As these areas were accessible to people and visitors, this could put them at risk of infection. We also saw broken equipment such as wheelchairs and old carpet being stored on the floor of this area. We told the provider about this and they arranged for a skip to be delivered in order to clear this area.

Staff were failing to follow safe infection control policies and procedures; we saw a number of staff members with long hair, wearing their hair down whilst providing care and support. There were also a number of staff members seen wearing rings with large stones and bracelets, both of these could cause harm to a person, and were also an infection control risk due to it being difficult to clean them sufficiently. A laundry bag containing soiled items of clothing was left on the floor outside of the lift. We found that the air vent on one of the bathrooms was covered in dust and dirt; and a shower chair was still wrapped in its bubble wrap and the waste water drain in the shower was full of stagnant water showing that these areas hadn't been cleaned effectively and putting people at risk from harm.

The service had a designated laundry area, with a door where dirty laundry can be taken in and a door where clean laundry can exit. We saw that neither door was kept secure, posing a risk to people due to the cleaning products stored in this area. We also saw the clean laundry being taken through the dirty laundry door to go on the trolley to be delivered to the people throughout the home. The infection control guidance for care homes, states that dirty laundry should arrive through one door and be removed through a separate exit to a clean area. This was not happening and put people at risk of cross infection.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. We found these measures had not been taken in relation to the environment and staff practices. The provider's policy on infection control was out of date and did not follow best practice guidance. Consequently the provider could not demonstrate that the risks of people developing an infection had been identified and were being managed effectively.

The failure to maintain a clean environment and equipment, or to follow infection control guidance, was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection process, we looked at the administration, storage and disposal of medicines within the home.. On the nursing floor we saw the registered nurse on one of the days, signing the medication administration record (MAR) to say they had been administered and then taking them to the person. This meant that if the person had refused, the nurse had already signed to say they had taken them which was not safe practice. NICE guidance recommends that staff only sign once the medicine has been administered. We also saw for one person, there medicines were left in a pot on top of the trolley for over thirty minutes before being taken to the person. The 'potting up' of medicines is poor practice and the thirty minute delay could have resulted in the medicines being given to the wrong person. A relative told us they were often given the medicine to administer to their loved one as the person could be non-compliant with staff. This meant the medicine was being secondary dispensed and the member of staff could not be sure the medicine had been administered. We also saw single use syringes being used to draw up medicines, and then instead of being disposed of they were being put back in their packet with the medicine to be used again. There was evidence that this was happening as there was residue in the syringes being used. On the residential floor we saw safe practice, whereby the senior carer administering the medicines ensured the person took the medicine as prescribed before signing for it.

We saw topical creams left open on the sides of tables in people's rooms and also on a small table in the lounge. These were not named and there was no date recorded as to when they had been opened. Meaning they could have been open longer than the recommended three months. We also saw a topical patch, used for the treatment of wounds, with one person's name on and prescribed in January 2015, yet this was in someone else's bedroom on a chest of drawers. This is poor practice as it was unclear whether the person, who was named on the patch, still required them or whether it needed to be disposed of.

There were no protocols kept with the MAR's for people needed 'as required' (PRN) medicines or required their medicines to be given covertly. We did see a protocol in someone's care plan for PRN paracetamol which had last been reviewed in January 2016. Not keeping the protocol with the MAR meant that the person administering the medicines did not have it with them and would not be able to follow the advice recorded.

We found the medicines fridge was not kept locked and there was no safe disposal of medicines being used. We found open bottles of alcohol, staff bags and coats being stored in the treatment room. There was also dust gathered on the computer which was stored in the room. This showed that the room had not been cleaned thoroughly and there was a risk of infection.

Failure to administer and store medicines safely was a further breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The service did not have a robust recruitment process in place.. Checks had been completed with Disclosure and Baring Service (DBS) prior to staff starting working in the service. The DBS is carried out to ensure staff are suitable to work with people who live at the home. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw that two references had been obtained for each staff member and application forms had been completed. We found that where recruitment checks had had raised concerns about a member of staff, there was no evidence to show what additional checks had been made by the service. and there was no evidence that a risk assessment had been undertaken, detailing what actions had been put in place to ensure the safety of the people living at Polefield Nursing Home.

Registered nurses are required to be validated with the Nursing and Midwifery Council (NMC) and have valid pin numbers. We saw pin numbers for the registered nurses had been recorded, but no date of when their

pin numbers expired. This could lead to a member of the nursing staff being no longer validated to work as a registered nurse.

We found there were insufficient numbers of staff on duty, to meet the current level of needs of the people living at Polefield Nursing Home. There was a nursing staff member and two care staff on the nursing floor and a senior care staff and two care staff on the residential floor during the day. During the night there was a nursing staff member and one care staff on the nursing floor and two carers on the residential floor. We observed one person who was reported to be doubly incontinent, sat in a chair in the lounge for the whole time we were there, at no point during the day was this person moved or their continence pad checked. We also observed people on the residential unit, shouting out for support and on the nursing unit we heard a member of the domestic staff, ask the nurse where the two care staff members were as a person needed support. We were told by the provider, that staffing levels at Polefield Nursing Home were not calculated by using a dependency tool. They told us that this was not needed, as there were "enough staff members" and he had received no complaints that they were short staffed. However, staff we spoke with told us that people's dependency needs had increased and they felt they needed additional support at specific times of day, for example, in the mornings when providing personal care and support. If the person they were supporting required two carers to meet their needs, this meant that at present there was no one available to support the other people living at Polefield,Nursing Home as the senior/nurse on duty was administering medicines. One staff member said, "We could do with one extra member of staff in the mornings". Staff members stated that this extra staff member could work between the nursing and residential floors, as required.

The failure to have sufficient staff on duty was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff members were able to describe different types of abuse and risks which may pose harm to those living at Polefield Nursing Home. All care staff we spoke with knew what to do if they suspected abuse and who they would report it to. However we found that seven staff members had not undertaken refresher training and three staff members had not had any safeguarding training at all. We noted that accidents and incidents had been recorded but not all serious injuries had been reported to the appropriate bodies such as the local authority or the Care Quality Commission.

Requires Improvement

Is the service effective?

Our findings

Staff showed an understanding around consent. We saw that before people received any care or support, staff asked for their consent and acted in accordance with their wishes. One staff member told us, "We generally just ask people, if we don't feel they are able to answer then we need to consider what is in the person's best interest." Staff had a general understanding of the Mental Capacity Act 2005 (MCA) and how this impacted upon the work they did. Staff were observed asking the people for their consent before carrying out any task.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

A high number of people living at Polefield Nursing home had bed rails attached to their beds, we saw there was a bed rail checklist in each person's file but there was no information about how the decision had been reached to fit them additionally there were no best interests decisions completed for people who required the use of bed rails and lacked capacity. There was a check list of whether the person was confused, but this did not show whether the person was able to consent to the bed rails and the service had not considered the least restrictive option.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. 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. We found that some people living at Polefield nursing home were subject to DoLS authorisations and that applications had been submitted for other people living at the service but it was not clear as to the reason for these applications. The provider told us, those with DoLS authorisations in place had been supported by independent mental capacity advocates to ensure the decision being made was in their best interest. These authorisations had happened prior to the provider taking over the service and we saw they were due to expire the week within a week of our inspection and the person would need to be reassessed.

The failure to follow the MCA and DoLS and obtain appropriate consent for the use of bedrails was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff told us they hadn't received updates in their essential training as they are required to, in over a year. The training matrix confirmed that essential training in areas such as fire safety; infection control and food hygiene had only been completed by a few of the staff. We found that none of the staff members had received any updated training on managing PEG feeds whilst working at Polefield Nursing Home, despite there being people living there whose nutritional needs were managed this way. This meant staff did not have the current training to manage these people's needs safely. We spoke with the provider who was aware

that the training had not been kept up to date. He told us that he was investing in an online training system, so that all the staff can access the essential training quickly, without impacting on the care and support required within the service. Staff confirmed that they were aware that this was being arranged and felt that the provider would ensure this happened as soon as possible.

The failure to ensure all staff are appropriately trained to carry out the role safely was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff were aware of people who required a specialised diet and the reasons why they required it. People had been involved with the menu planning and the meals we saw appeared to be nutritious. We observed people being offered choice, but this wasn't always in a visual form, to aid those who had a cognitive impairment to make their decision. Two people we spoke with both said, "The food is alright" and staff commented that the food can be "very good, or not so good. They have re-jigged the menus and there have been some improvements". We observed the mealtimes and saw they were not sociable occasions. People either ate in their rooms or sitting in their chairs around the edges of the lounge. The dining rooms weren't being utilised and there was no menu or images of what was about to be served.

People had access to doctors and referrals were made to speech and language therapists (SALT) when required. We spoke with a visiting SALT who confirmed that referrals were made appropriately and in a timely manner. We also saw the community nurses visiting people on the residential floor, as well as a member of the continuing health care team (CHC), who was there to assess someone for CHC funding. Care files we checked showed when referrals had been made to healthcare professionals and the reason they had been made.

Requires Improvement

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "The carers are nice", another said, "The carers are alright, they work hard". A third person told us, "I'm being looked after; I get on with all the nurses."

A nursing staff member told us that no one was on an end of life care plan. However, one of the care files showed that one person on the nursing unit was on an end of life plan. There was a copy of the person's statement of intent to allow the GP to issue a medical certificate of cause of death. We found there was no care plan surrounding their wishes within their care file as documented in the index of their care plan profile. We saw within people's care files there were instructions "do not attempt cardio pulmonary resuscitation" (DNACPR), these showed where the person had been involved in the decision.

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We observed caring interactions between the people, their relatives, care staff and other professionals. Staff knew who they could engage in banter with, and those who required a more sensitive or formal approach. Relationships between the staff and visitors were warm and friendly and there were no restrictions on people having visitors. Staff showed concern for people's wellbeing in a caring and meaningful way. For example a staff member noticed a person had slipped slightly in their chair and was rubbing their leg, the staff member got down to the person's level to make eye contact with them, before asking them if they wanted a foot stool to rest their legs and make them more comfortable.

Staff knew the people they were supporting and this showed in the way in which they provided their care and support. Staff were able to describe people's individual needs, preferences and choices. Staff were able to describe to us how they promote the independence of people by encouraging them to do as much for themselves as possible and not take over. People were supported to be as independent as possible to the full extent of their abilities. They were able to move freely around the house and choose where they spent their time. Staff encouraged people to make choices for themselves; we observed staff asking people if they wanted to participate in activities and waited for a response from them.

On occasion, the care and support people received was rushed and staff were task focused. When spoken with, they explained that they would like to spend more time with people, however due to an increase in

people's dependency levels they weren't able to spend as much time with people as they would like. People told us staff were busy; one person said "They [the carers] work so hard". A relative said they felt that at times, staff were "task orientated".

People's privacy was protected. All the care files were kept confidential in locked cupboards; meaning only those staff members who needed to see them, had access to the information.
Staff were seen respecting people's privacy by always knocking on people's doors before entering. Staff described practical steps they took to maintain people's dignity, such as partially covering them with towels when delivering personal care. For people who shared a room staff explained they would close the curtains which divided the room. People's dignity was respected by staff, using people's preferred names.

Requires Improvement

Is the service responsive?

Our findings

When people moved to the home, they, and their families where appropriate, were usually involved in assessing and planning the care and support they needed. People had signed relevant sections of their care plan and the pre-admission form was detailed and provided information to staff about the person's individual needs and preferences. However, some people told us they had not been involved in planning the care they received and were not consulted when their care plans were reviewed. One person told us they were, on the whole "happy with the care being provided" at Polefield Nursing Home.

We found that people's care plans were generic, with blank spaces to insert the person's name and used the terms his/her. They were task orientated and not personalised to the individual preferences of the person. We saw they were more about the person's 'conditions' rather than about what the person was able to do and what they needed support with or who they wanted to support them. Staff said they knew the people and would always ask before carrying out any care or support. We saw this was the case by the way in which the staff asked people's permission before they carried out any care or support. We saw one person refuse their lunch time meal; staff encouraged the person to try some and offered other choices instead. One person complained they were hungry and was immediately given a bowl of cereal (which was the person's choice). Care plans were being reviewed monthly on the nursing floor but this wasn't always the case on the residential floor. People who had capacity had not been included in care plan reviews.

The failure to ensure all care plans were personalised to each person was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with knew what person-centred care meant and could describe how they provided it. They knew people's likes and dislikes and were knowledgeable about people's individual needs and how to ensure these needs were met. These were recorded in the person's pre-admission documents, but had not been transferred to the person's individual care plan. Staff explained that people were given the opportunity to make choices about their care enabling them to be involved in decision making. However, we found care plans had been implemented in relation to meeting people's needs but were not kept up to date. We found in one person's care file it was recorded their nutritional needs were met via a tube into their body (PEG), and they had a care plan stating they were nil by mouth (NBM). We found a second care plan for this person, along with a nutritional score which gave conflicting information and stated they were able to eat a normal diet. Both care plans had been reviewed but neither updated to reflect the current support required to maintain the parenteral nutritional and hydration needs of this person. This could put the person at risk from harm.

The service employed an activities coordinator who was spending time completing activities in the lounge of the residential unit. People who were able to leave their rooms received the mental and physical stimulation they required on a regular basis. However this was not the case for everyone. During the two days of the inspection we saw minimal activities occurring with people who were nursed in their beds. It was not clear as to whether this was their choice or due to their physical health needs. They were predominately being cared for on the nursing floor and the activities were being held on the residential floor. Though the

activities coordinator told us they tried to spend time with those people who were being nursed in bed, on a one to one basis. We saw evidence of this on the residential floor, but not on the nursing floor.

We asked people about activities they took part in. One person told us, "It's boring; I can't just go out on my own as I am scared of falling". Another person said, "I'm bored, I feel a bit down". When asked if they wanted to join in with the activities, the person declined. Staff told us that there were activities on Monday – Friday, but it could be "frustrating at times as only two people will attend". This could mean that people were not interested in the activities on offer. We observed people taking part in armchair aerobics during the morning, and then three people took part in the karaoke in the afternoon. People appeared to enjoy this activity as everyone who was sitting in the lounge, joined in and those who were unable to sing, were observed smiling and nodding in time to the music. Staff told us there had been an organised event at Easter and they planned to have more when the weather improved. They were also plans to have day trips out; as they had done in previous years and a staff member said they planned to discuss this at the next residents' meeting in order to get input from people living at Polefield.

We saw photographs of recent activities displayed on the wall of the nursing floor. People appeared to be enjoying the activities they were participating in. We spoke with the activities coordinator who was relatively new in post who explained their vision for the role. At present they were completing 'My Life Story' with each person living at Polefield. These contained details about the person including their preferred name, those important to them and things about their past which meant a lot to them. There was an activities board which was updated each week.

People told us there had been residents meetings held, but these had not been for some time. The last recorded residents meeting had been in October 2015, however we were told by the provider there had been one since then but it wasn't recorded. We spoke with the staff who confirmed that a residents meeting had been held but as yet one had not been arranged.

We saw there was a complaints procedure in place. There were notices on the wall, advising people ways in which to complain. We noticed these were old and the information provided was out of date. This was raised with the provider, who updated the details on some of the notices, but not all of them. When asked about the complaints procedure, the provider told us that they had only received one complaint this had been dealt with at the time. People said if they weren't happy with anything, they would just tell the staff.

Inadequate

Is the service well-led?

Our findings

People's experience of care was not being monitored through a range of reviews or audits. Quality assurance checks had not been carried out since 2014, prior to the current provider purchasing the home. We found that some care plans were being reviewed monthly in order to check they remained up to date, however, when there were changes to people's care and support needs, the care plans did not reflect this. Monthly audits with action plans had been completed for accidents and incidents. We found that the provider had not identified or taken action with regards to environmental issues such as no radiator covers, which we identified as posing a serious risk of harm to those people living at Polefield Nursing Home. Effective systems were not in place to monitor, assess and improve other aspects of the service; these included infection control, the management of falls, the operation of recruitment procedures, the implementation of the MCA, staff training, the recording of the care and support delivered and the analysis of feedback from satisfaction surveys. Consequently the provider had failed to identify or implement improvements that were needed. We discussed this with the provider who told us they had already identified the concerns raised and were planning to introduce a new care planning process and to review their quality assurance as part of this. However they had failed to take any action prior to the inspection meaning they had not been operating an effective system and process to make sure the service maintained accurate records and practised good governance.

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

Policies and procedures were out of date and not being followed by staff. We raised this with the provider who told us they planned to purchase some new policies and staff would then need to read them and sign to say they had read them.

The service did not have a registered manager as required by the Care Quality Commission (CQC). The registered manager had resigned a few weeks prior to the inspection. There was no deputy manager in post and no leadership for the staff and roles responsibilities and accountability not clearly defined or understood. Since the registered manager left, there was no one to take ownership of this role. The provider told us they planned to become the registered manager but they were not always visible in the home and staff told us that the provider arrived at varying times of the day and there was no leadership. We asked care staff how the service was being managed and led. We were told they felt "unsupported by the registered nurses" who spent the shift administering medicines. A relative told us they felt the staff weren't being supervised, and were doing their own thing. There was 'no leadership'. We observed two care staff providing all the care and support at mealtimes with no support from the registered nurse. As they were still administering the morning medicines, despite it being lunchtime. This meant that those with high dependency needs who required assistance with eating their meal would have to wait for one of the carers to be available in order to support them.

All staff we spoke with told us they liked working at Polefield nursing home and believed there was an open

culture. Staff we spoke with felt they were unable to comment on the support they received from the provider as they had not needed to approach the provider at this time. When asked if they felt they were able to approach the provider if they had any concerns or issues, everyone we spoke with said they felt they would.

Everyone we spoke with knew who the provider was; one person told us "I've seen him [the provider] around". The provider told us they had held a meeting with people living at the service and their relatives to introduce themselves. Issues had been raised at these meetings about laundry going missing, so the provider had taken action and purchased name tags. However no other meeting had been held since this one and no meetings had been arranged. We saw a questionnaire had been sent out to the people living at Polefield nursing home, however we saw actions had not been taken to address any concerns. For example; Five people of the 23 people who completed the questionnaire, stated they either disagreed or strongly disagreed that there were sufficient staff, with three people neither agreeing nor disagreeing.

The provider explained that the vision of the service was to provide; safe, responsive person-centred care and ensure that the service is meeting the standards. We found that the service was not working to this. The service was not safe, responsive or person centred. There was no clear clinical governance and medicine administration was not safe.

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We identified three incidents within two people's care files which had not been reported to CQC. For example; we saw one incident where a person had fallen which had resulted in the service ringing 999 and the person was taken to hospital. We raised this with the provider who was unable to say why these had not been reported as there had been a registered manager in post at the time of the incidents.

Staff meetings were not regular, staff told us and documentation showed there had only been one staff meeting since the new provider became registered and that had been held in November 2015, and this had been an introduction to the staff and to discuss the changes in the way in which they were to work. For example, staff now worked on designated floors, in order to aid continuity of care which was a positive change.