Bupa Care Homes (ANS) Limited

The Polegate Nursing Centre

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

Overall summary

The Polegate Nursing Centre is part of the large Bupa organisation and is registered to provide residential nursing care for up to 44 older people. There were 43 people living at the home at the time of the inspection.

People required a range of help and support in relation to their care and welfare. This included personal support with nursing needs, poor mobility, dementia and end of life care.

The home is purpose built, with a passenger lift, and wide corridors to assist people to access all areas of the building.

This was an unannounced inspection which took place on 14 and 15 December 2015.

At the time of the inspection the registered manager was no longer working at the service and was in the process of de registering as registered manager with CQC. A new acting manager had been working at the service for four weeks, supported by the current registered manager. The acting manager had begun their application process to register as manager of The Polegate Nursing Centre. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered

Summary of findings

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 acting manager was in day to day charge of the home. People told us they had met and spoken to the new manager. Visitors and relatives spoke highly of the manager and told us that there was always someone available to speak to when needed.

We found areas of medicine administration and documentation needed to be improved to ensure people received their medicines in a safe and consistent manner.

People's privacy and dignity had not been maintained. People with dementia were not always spoken to in a patient and caring manner. People's personal information was left on view regarding people's personal care and health needs. Staff were seen to have discussions around care and each other within earshot of other people living in the home. People told us staff had spoken to them about the home, other staff and the work load whilst they were being assisted with personal care.

Care documentation, daily records and charts needed to be improved to ensure relevant information was captured throughout the day.

People's dependency levels were reviewed and assessed to establish the number of care and nursing hours required. However we saw that people did not always receive assistance in a timely manner. People, relatives and staff we spoke with expressed concern around workloads, call bell answering and assistance with personal care and at meal times.

There were systems in place to assess the quality of the service however these had not identified shortfalls around daily documentation and end of life care. Appropriate maintenance, infection control and health and safety checks were carried out and regular servicing of equipment took place.

Feedback from staff was mixed and some felt that communication between management and care staff needed to be improved.

Fire evacuation plans and emergency evacuation equipment and procedures were in place.

Staff received training which they felt was effective and supported them in providing safe care for people. Recruitment checks were completed before staff began work and there was a programme of supervision and appraisals for staff.

Staff demonstrated a clear understanding on how to recognise and report abuse. Staff understood their responsibilities to ensure people were kept safe.

A weekly leaflet was produced informing people 'Whats on' for the following week. People were encouraged to participate in daily activities; we received positive feedback from people who attended.

People, relatives or significant people were kept informed when there had been a change to people's health. Relatives told us that the acting manager and staff were very supportive.

Feedback was gained from people and staff in the form of questionnaires and meetings.

People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes. Menus were reviewed and changes made when requested.

Notifications and referrals were made appropriately to outside agencies when required.

We found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Medicine procedures needed to be improved to ensure people received their medicine safely and in a timely manner. Procedures and documentation for 'as required' medicines needed to be improved.

Dependency levels were assessed, to determine staffing levels required, however, it was unclear how staffing levels were reviewed to take into account when people's needs fluctuated or when people became unwell.

Staff had a good understanding about how to recognise and report safeguarding concerns.

Environmental and individual risks were identified and managed to help ensure people remained safe.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's involvement in decisions and care planning documentation was not clear.

Communication between staff needed to be improved.

All staff had received effective training to ensure they had the knowledge and skills to meet the needs of people living at the service.

Staff had regular supervision and appraisals.

Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS)

A varied menu was available for people. People gave positive feedback around the high standard of meals. Meal choices were provided and people were encouraged to maintain a balanced diet.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always treated with patience and dignity.

Confidentiality of documentation and personal information had not been maintained. Personal information regarding peoples care needs was repeatedly left in open view.

Summary of findings

Adequate support and was not in place to ensure people's end of life care needs were met.

Staff knew people well and were able to tell us about people's likes and dislikes.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Daily records were not clear up to date and contemporaneous. Information around care provided had not been kept up to date.

When people's health deteriorated documentation did not evidence actions taken.

Daily activities were provided for people to allow them to spend time doing things they enjoyed.

Pre- admission assessments were completed and care plans reviewed monthly.

People were encouraged to share their views. A complaints procedure was in place and displayed for people to access if needed.

Is the service well-led?

Requires improvement

The Polegate Nursing Centre was well led.

There was a newly recruited acting manager who had begun the process of registering with CQC.

There were systems in place to assess and monitor the quality of service provided. However, shortfalls to daily records and recording had not been identified.

End of life care documentation needed to be improved.

Audit information was used to continually improve and develop the service.

The acting manager had identified areas of improvement and begun implementing changes in the short time they had been in post.

Notifications of accidents, incidents or untoward events had been referred appropriately to CQC and the local authority when required.

The Polegate Nursing Centre

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 which took place on 14 and 15 December 2015 was unannounced and was undertaken by two inspectors.

The last inspection took place in June 2014 where no concerns were identified.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and any other information that has been shared with us.

A Provider Information return (PIR) had not been requested as this inspection had been bought forward. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Some people living at The Polegate Nursing Centre were able to tell us about their experiences of living at the home. Others were not able to tell us about their experiences; therefore we carried out observations in communal areas and spoke to visitors and relatives.

We looked at all care documentation for three people and a further four care files to follow up on specific areas of documentation. We read daily records, risk assessments and associated daily records and charts for other people living at The Polegate Nursing Centre. Medicine Administration Records (MAR) charts and medicine records were checked. We read diary entries and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff, resident and relatives meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for six staff and records of staff training, supervision and appraisals for all staff.

We spoke with eight people using the service and 14 staff. This included the manager, deputy manager, care and activity staff, chef, housekeeping, maintenance and other staff members involved in the day to day running of the service.

We spoke with four relatives and one visiting professional to gain further feedback about the service.

Requires improvement

Is the service safe?

Our findings

People said they felt safe living at The Polegate Nursing Centre. We were told, "Yes I feel safe here." And, "My room is kept nice and I have a bell to use if I need any help." Relatives told us, "I feel that my wife is safe, I don't worry about her when I am not here." And, "I can speak to the manager she's been such a support I know that Mum is being looked after here, it's been such a relief."

Despite this positive feedback we found that people did not receive their medicines appropriately. On the morning of the inspection people were still receiving their morning medicines at 11.15am. Medicine Administration Records (MAR) stated that morning medicines should be given at breakfast time, although no specific time was detailed to show what time this was. It was unclear what had caused the delay and we saw that MAR charts did not include any details regarding the actual time they were being administered. This meant that if the Registered Nurse (RN) had been called away a covering nurse would not be aware of the time medicines had been administered. For medicines including those taken for pain relief, for example paracetamol based medicines and strong pain relief medicines, these have specific time periods between each dose to ensure they are administered safely to prevent over dosing and contra- indications. This did not ensure people received their medicines in a safe manner.

We looked at documentation for PRN or 'as required' medicine. Whilst PRN protocols were in place, they were not being clearly followed. PRN protocols should identify what the medicine is, why it was prescribed and when and how it should be administered. This is to ensure that people receive their medicines in a safe, consistent manner regardless of who is administering it. PRN medicines are prescribed by a person's GP to be taken as and when needed, for example pain relieving medicines. We saw that PRN medicines had designated times highlighted on people's MAR charts. PRN should only be dispensed if the person requests it or a trained staff member identifies that a person may be in pain or require the PRN medicine. When PRN medicines had been administered the RN had not written any details regarding the time and reason for administration. This meant that PRN medicines were not being given as and when required in accordance with how the medicines had been prescribed.

We looked at people's care documentation around medicines. We found that one person care documentation contained information that they required their medicines to be given in yoghurt to aid swallowing; however this information had not been included in other areas of care documentation including the MAR chart to support staff in providing safe care. We spoke to the RN on duty who told us this was dependant on how the person was each day and that this information had been handed over to her at morning handover. This meant that staff on duty may not be aware how to safely administer this persons medicines and were reliant on verbal information being shared correctly. These issues meant that the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures were in place to support safe administration and management of medicines. The RN on duty administered medicines. Medicines were regularly audited to ensure that medicine administration systems were maintained to a high standard. People who wished to were able to self-administer their medicines. All medicine risk assessments and care plans were reviewed monthly or more frequently if there were any changes to people's health.

Medicines and topical creams were stored and disposed of appropriately. Medicines were labelled, dated on opening and stored tidily within the trolleys on both floors. Medicine fridges and medicine room temperatures were monitored daily to ensure they remained within appropriate levels. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

During pre-admission and subsequent reviews a level of need assessment was completed. This was called BUPA resident care need banding. And included levels from band 1 to band 4 dependant on peoples assessed criteria. For example, low or high complex care needs, assistance required with some or most activities of living. This identified the number of hours of carer input and nursing care needed per day. The acting manager told us this was a generic BUPA assessment criteria used to determine staffing requirements. The acting manager told us that staffing levels were designated at four care staff and one registered nurse on each of the two floors. We looked at the staffing rotas over a three week period including the time of

Requires improvement

Is the service safe?

the inspection and saw that there had been shifts that had fallen below this designated staffing level for care staff. The acting manager told us that when people were sick all possible steps were taken to cover a shift, however, on occasions this had not been possible at short notice. Staff told us, "They don't like to use agency, they say it's not consistent for people as they need a familiar face, but they don't like to use them, we are often having to move around the building to help each other out as one area is short." We discussed the use of agency staff with the acting manager and saw invoices to show that an agency RN had worked at the home in November and during October four agency care staff had been employed to work shifts at The Polegate Nursing Centre.

Care staff told us, "It is high dependency downstairs and on Saturday we were short, only two carers and me. I was so upset that I rang my husband crying. It's nearly every shift and we are told that we can cope as we're not full capacity. Patients are not getting the care they should have and there's no time to communicate. Another said, "They are employing all the time but they only last a few shifts and they haven't the experience. We can't wash 22 people properly; they're not getting the care." And, "The last few months we have been short with people leaving and off sick it's been a stressful few months. There's no bank and the RNS are supposed to help but some don't as they have the meds and paperwork to do, they are so busy with their bits to do."

Staff also told us, "It's always busy and sometimes we are short staffed, people have a lot of needs and need two staff to help them, it's a struggle." And, "The shifts change at short notice, we are often short staffed in the afternoon, and when we say anything we are told there are enough, but it doesn't feel like that when you can't spend any time with people." Residents and relatives told us that call bells were constantly ringing. We were told, "The bells are going all the time, its disturbing when you are trying to sleep. You hear staff answer bells and saying they will be there soon as they are helping someone else, you feel for them as they are dashing from person to person." And, "The call bells are ringing all the time, it's even worse at night."

During the afternoon on the second day of inspection a member of care staff was off sick. Staff told us that someone was meant to come in and cover the shift but they had not turned up. A staff member had been asked to stay to do the tea and coffee round for people and another member of care staff had been asked to 'float' on both floors to assist. We observed how busy the two remaining care staff were as a high number of people required the assistance of two care staff for all their care needs. One person required a higher level of assistance due to deterioration in their health and another was feeling unwell and needed extra support with eating and drinking. The RN told us they did not have a lot of time to assist the care staff as they were doing medicines and other nursing tasks. This meant that staff were seen to be rushing between tasks and people we spoke with felt that staff did not have time to spend with them.

Daily records had not been completed and staff told us they had to do these at the end of a shift as there was no time during it to get things written down as they were too busy. It was unclear how assessments and care need bandings took into consideration the fluctuating daily needs for people and what provision was in place to ensure this was addressed when needed for example, people whose care needs may be higher if for example they felt tired or unwell. For people who were assessed as requiring end of life care, care staff were seen to struggle to be able to spend adequate time with this person when they became upset and needed extra encouragement and support with personal care needs. This is an area that needs to be improved to ensure peoples fluctuating care needs could be met at all times. The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were available at all times to meet people's care and treatment needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to help protect people from the risk of harm or abuse. The manager was aware of the correct reporting procedure for any safeguarding concerns. A safeguarding policy was available for staff to access if needed. Staff had received safeguarding training and demonstrated a good knowledge around how to recognise and report safeguarding concerns.

People at The Polegate Nursing Centre had a range of nursing and care needs. These were assessed and reviewed monthly to ensure that the home could provide safe care. Moving and handling risk assessments had been

Requires improvement

Is the service safe?

completed, these detailed how many staff were needed to assist people on a day to day basis for example assistance with personal care and people who required end of life care.

Risks to individuals were identified this included falls, use of bedrails, nutrition, tissue viability and any other individual risks identified during the initial assessment. People's care and health needs had been considered in relation to their safe evacuation in the event of an emergency. Fire alarm and emergency lighting checks had taken place regularly to ensure people's continued safety. Personal emergency evacuation plans (PEEPS) were in place with plans of the building, fire safety and evacuation information. There was regular training for both day and night staff and evacuation equipment was located around the building to aid evacuation. A contingency plan was in place in the event of an emergency evacuation being required.

There were robust systems in place to ensure the safety and maintenance of equipment and services to the building. All maintenance and equipment checks had taken place with certificates available to confirm this. For example legionella water checks, personal appliance testing, and gas safety checks. Staff told us all maintenance needs were addressed promptly. A full list of emergency contact numbers were available for example gas, electricity and lift maintenance contractors.

The registered manager had a thorough recruitment system in place. We looked at staff recruitment files; these included the staff file of a newly employed staff member. All files showed relevant checks which had been completed before staff began work. For example, disclosure and barring service (DBS) checks, a DBS check is completed before staff began work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment.

Staff had access to relevant and up to date information and policies, including whistleblowing and safeguarding. Policies were reviewed and updated when changes took place; this included the addition of new policies to incorporate recent changes to regulation. Staff told us they knew where policies were stored and that they were asked to read and sign them when changes occurred to ensure they were aware of correct working procedures.

Incidents and accidents were reported and the manager had oversight of any incidents/ accidents or falls that had occurred. A monthly review was completed and these were analysed to look for any trends to ensure that future risks could be avoided if possible. The manager and staff understood the importance of learning from incidents to facilitate continued improvement within the service. For example, if someone had a fall, then this would trigger a review to look at how the person's safety could be supported to prevent further incidents if possible.

Requires improvement

Is the service effective?

Our findings

Everyone we spoke with told us they were aware that there had been a number of management changes over recent months. People told us they had met the new acting manager. Relatives we spoke with told us the acting manager was open and approachable and we witnessed a number of visitors 'pop into' the manager's office to chat and to speak privately. Everyone spoke of the 'open door policy and staff told us, "If the managers door is shut then we know someone must be in there talking to her as otherwise the door is open and you can just pop in."

Despite this positive feedback, people's choice and involvement in care planning and reviews was not clear. For example, when people declined assistance with personal care, care staff did not explore the reasons for this, or talk to the person to try and encourage them. Although staff understood that people had a choice and were able to decline, for those who were unwell and at risk of pressure area breakdown suitable steps had not been taken to facilitate open communication and establish the reasons behind this and seek mutually agreed solutions.

People told us they had not read their care information and we saw limited evidence that peoples next of kin or representatives had been involved in decisions documented. One person who had full capacity to be involved in decisions was at the home for a period of respite, they told us, "They did a really full assessment before I came here, but I have not seen anything or signed anything since." This was an area that needed to be improved.

Relatives told us that if their loved one became unwell a member of nursing staff rang them. We saw that the manager telephoned relatives to keep them up to date when someone became unwell and visitors felt able to speak to staff and management if needed.

Staff told us that they felt that communication was not effective between all levels of staff. They gave examples about changes to shifts and rotas not being communicated in a timely manner and felt that the manager may not be aware of the difficulties they were having with regards to meeting people's needs. The manager had only been working at the service a few weeks. In that time they had implemented a daily 10am meeting. This was a short meeting which included representatives from domestic, kitchen, RNS, senior carer, activities person, and maintenance and management staff. We observed a daily meeting and saw that this was used to share relevant information and update everyone on any issues or concerns that needed to be addressed that day. We spoke to care staff later and it was unclear whether all information from these meetings was being fed back to them and this was causing the breakdown in communication they felt was occurring.

People received care from staff who had knowledge and skills to look after them. RN's had checks in place to ensure they were appropriately registered the manager was able to give us a list of trained staff with all current NMC registrations documented and up to date to 2016. RNs told us they felt supported to ensure their skills were maintained, for example some had recently completed syringe driver training. There was a full and intensive programme which included all essential training for staff, with further training for example National Vocational Qualifications (NVQ) or similar for care staff. Staff told us the training they received enabled them to understand people and supported them in being able to meet people's needs.

New staff completed a period of induction. The acting manager had also completed this induction.

Staff files included details of induction programmes completed including the new Care Certificate Standards induction. The Care Certificate sets out the learning outcomes, competences and standards of care that are expected from care workers to ensure they are caring, compassionate and provide quality care. The manager told us that all new staff had to complete the one week induction programme before permitted to work 'on the floor', this included completion of mandatory training. Once employed staff received regular supervision and appraisals. Supervisions were documented and staff knew when they were due to take place. Staff told they found supervisions helpful as it was their opportunity to discuss the thoughts and feelings. Supervision records where signed by staff and stored in staff files. Disciplinary policies and procedures were in place and documented in staff files to show actions taken and further supervision or actions taken if needed.

The manager had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. When applications had been required, for

Is the service effective?

example due to a change in a person's behaviour which may put them at risk, referrals had been made. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests. Mental capacity assessments had been completed in care files. For people who did not have capacity to make decisions about their care and welfare best interest meetings and decisions had been documented to support any decisions made. Staff demonstrated an understanding of MCA and its aims to protect people who lack capacity and when this might be required.

People were supported to maintain a balanced and nutritious diet. People's weight and nutritional intake were regular monitored when necessary and we saw that referrals had been made to Speech and Language Specialists (SALT) in the past if people's nutritional intake was reduced or staff had any concerns around people's eating and drinking. People told us that meals were "Absolutely delicious, so much choice", And, "If you ask for something it's normally available." Another person told us there were specific foods they would like to have however, they had not shared this information with the chef or staff. We shared this information with the acting manager who asked the chef to discuss likes and dislikes again with this person." Relatives told us that meals, "Always looked appetising."

There was a weekly menu with choices and alternatives available for people. People's preferences, likes and dislikes were well recorded. The chef was advised of people's likes and dislikes and had details of those who had special dietary requirements. This included diabetic, soft and fortified diets. One person told us," 'The food is fantastic here, they are worried about me choking so I have to have pureed but I told them I wanted fish and chips pureed and the Chef came to see me and sorted it out."

There was a dining room on both floors for people to use if they chose. We saw that most people had breakfast in their room. At lunch time dining rooms were only used by a small number of people, others chose to eat in one of the lounge areas or in their rooms. For people who remained in bed meals were taken to their rooms. We saw that in the lounge area on both floors a member of staff remained with people.

Requires improvement

Is the service caring?

Our findings

Feedback from people was mixed. Some people told us that they thought staff were caring. We were told, "They are really busy but they do their best." And, "They come to help me when I need it, the staff are very nice." However, we were also told, "I can be dying to go to the loo and I'm told to wait. Its got worse this year there should be four staff and often it's two and it takes two to hoist me. It's often later when they come they are so busy and it's getting later." And, "It's not very dignified when you have to keep asking for help when you need the loo."

We carried out observations around the home and found that staff did not always respond to people in a polite and dignified manner. We observed one member of care staff respond to a person with dementia in a curt and abrupt tone of voice. This was bought to the attention of the manager and dealt with in a timely manner. Staff were seen to have open discussions in corridors outside people's rooms when doors were open. This included staff discussing other people's care needs, who still needed assistance with personal care and their dissatisfaction around the work load and other staff members. We asked staff how people's privacy and dignity needs were met. Some staff lacked insight regarding dignity for people telling us, "We cover them when taking them from the shower to their room." And, "We close the door and curtains when we are doing personal care and ask relatives to wait outside."

Confidential documentation was not stored safely and securely. Care files were left open on the nurse's desk whilst the area was unattended, cupboards containing care documentation and confidential details regarding people's health and care needs were left open and unlocked at the nurse station on both floors throughout the day. A list written by a member of staff with columns titled 'bed, pad, toilet' and a list of people's names below, was left on a clipboard on view at the nurses station on three occasions despite being moved by the inspector as this was in direct view as people entered or exited the lift. People living at The Polegate Nursing Centre told us information they had overheard carers discussing, including their thoughts on other staff members. People also told us staff discussed with them that they were not happy with the number of staff and the workload whilst they were assisting them in their rooms. This was not a caring and dignified approach to care.

At meal times staff were seen to go from person to person helping them with their meals. On two occasions staff stood over people whilst assisting them rather than sitting next to the person to providing support and aid communication. One person was seen to remain in bed through the day, their lunch time meal was on their bedside table. Over the course of lunch service on both days this person was seen to eat very little of their meal. Staff told us they had a very small appetite and needed constant encouragement to eat. Staff were seen to go into this person's room but only stayed with them briefly. Staff told us it was difficult to support everyone as many people needed support or assistance with their meals. We saw that one person whose health had deteriorated asked a member of staff to stay with them when they bought the meal into their room, however, this staff member was called away within minutes to assist another person. A relative arrived and took over supporting this person with their meal. These issues meant that the provider had not ensured service users were treated with dignity and responded to in a caring and compassionate way at all times. This is a breach of Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.

Despite these concerns we observed some staff supporting people with kindness and compassion and responding to people in a polite and kind manner. They told us, "I love my job and really enjoy looking after people." And, "I treat people how I would treat my mum or my nan, not everyone can speak for themselves that's why I am here to make sure they are looked after." There was a clear affection between people who had lived at the service for some time and specific members of staff. People told us that they really liked certain staff and enjoyed it when they were working. One carer had built a good rapport with a person and the mutual affection was clear. Staff knew people well and their likes and dislikes. The manager told us about one person who was struggling to drink unsupported but was reluctant to ask for assistance. After a discussion the manager had purchased a bone china cup and saucer similar to one the person had previously used at home. This was lighter and

Requires improvement

Is the service caring?

they were able to use this without risk of spillages. This meant that they had been supported to continue to remain as independent as possible whilst maintaining their dignity whilst drinking.

People had access to advocates when appropriate. Power of attorney information was included in care files alongside details of next of kin and representatives. Leaflets were available for people if they wished to find out more about independent advocacy services.

Requires improvement

Is the service responsive?

Our findings

People and relatives told us the manager and staff were responsive. Relatives felt they were kept well informed about any changes and were always contacted if someone became unwell. For example, one person had requested a visit from a priest. The home had contacted a priest and they were able to visit the person soon after. A family member told us that the manager and staff had supported them not only with their mother who was staying at The Polegate Nursing Centre but with their father who was elderly and was struggling to accept that his wife needed nursing care.

There was a clear system in place to assess, document and review care needs. Care files included care planning and risk assessments. However, some forms used for care planning information had headings which stated likes/ dislikes and this section had been used to document that the person had a learning disability. Information was included regarding people's lifestyle, medicines, safety, pain assessment records, skin care, along with information regarding personal care, nutrition, continence and background information.

People had been asked at their initial pre assessment whether they had any preferences regarding male or female care staff providing care. We asked staff how residents were able to have choice in their care. They told us, "By not pushing them to get up and asking them if they want to go to breakfast in the dining room. Most sit in a chair in their rooms and watch TV. One likes breakfast in the day room. We ask them each day as they have different moods." And, "After supper residents can do what they want they have the freedom to go to bed when they like and relatives can come in anytime." "There is person-centred care, one person wants a shower on Saturdays only and only wants me to do it and there are a couple of ladies that only like apple juice and one is a vegetarian. They can get activities and hobbies too. However, other members of care staff told us, "It can be difficult working around everything, residents are free to go in and out as they like." "We can't accommodate them getting up later as there are no staff to do the personal care during lunch that's the worst part as we need to make sure people get their weekly bath.

We asked care staff whether or not they read care documentation and if this gave them the information they needed to ensure care met people's needs. We received conflicting information two care staff told us, "All we do is daily notes there is no time to read care plans we are told that we are meant to.' And, "There's no time to look at care plans." Whilst others told us, "Care plans are done am and pm and the nurses review, the carers do it daily." And, "We can read the care plans and write in them am and pm and say what has happened in the day." "When we are doing care plans we can see what their lifestyle and likes and dislikes are."

Care records were typed and printed. Daily records competed by care staff, some entries were clear, well written and informative but this was not consistent. We saw that staff had crossed out areas of writing by scribbling over what had been written, there were spaces and lines when no information had been completed and entries were not always dated, timed and signed. This meant that it was difficult to get a picture of the care provided for people over a 24 hour period. Daily charts were being completed at the end of shifts; this meant that when people's notes were checked in the afternoon it was unclear what personal care they had received. This was an area that required to be improved.

For people who required end of life care, specific end of life care documentation was not in place to support staff. We found that it was unclear what further requirements had been catered for to ensure that end of life care needs were met. When people's health deteriorated and they required a higher level of care and nursing input this was not well documented in care files. For example, one person's care information was looked at 16.45pm. There were no entries for that day completed by care or nursing staff despite there having been a number of incidences when they had needed to provide assistance. Daily charts had not been completed so it was unclear when personal care had been offered and whether this had been declined. This was an area that was required to be improved to ensure people's care needs were being met. We saw that previous entries had commented that the person was complaining of pain, it was unclear from records what action had been taken in response to this. We discussed this with the RN and manager and were told that the GP had been contacted to review pain medicines for this person. Daily documentation was an area that required to be improved to ensure that clear, contemporaneous records were maintained at all times.

Requires improvement

Is the service responsive?

All care documentation and risk assessments were in the process of being reviewed by the acting manager to ensure information was relevant and up to date. There was a 'resident of the day' system where a resident had all clinical checks done such as blood pressure, urinalysis and visits from kitchen, domestic staff and people involved in the care delivery. The RN told us, "We check with them to see if they are happy and review the care plan." This ensured that all residents had a comprehensive review of care monthly. The manager told us that they then reviewed the care documentation the following day to ensure all updates and reviews had been completed, this was to ensure high standards of documentation were maintained. Any changes to people's health or care needs were promptly updated and information shared with staff at handover and during the daily meeting.

There were designated activity staff. A programme of activity was displayed and a schedule of planned activity called 'Whats on' was available for people to inform them of forthcoming events. People showed us a copy of the activities information they received each week, along with information provided on noticeboards. This included cards, games, visiting performers, trips to the shops and planned events. A Christmas party was scheduled for the following week. People told us they enjoyed attending activities and they were varied. People felt they were able to request things they would like to do. One told us, "The singing is great, even if I don't feel like going into the room, I can hear it in my room." People told us that they liked to stay in their room and watch television but they were asked if they wanted to go to activities. "It was up to them." There was an activity and interaction record used to record who attended activities and photographs of previous activities were displayed, with albums in the reception area for people to view, if they wished. Activity co-ordinators told us they visited people in their rooms if they were unable to attend activities to ensure people did not feel socially isolated.

People had the opportunity to share their views and give feedback during resident and relatives meetings. We saw minutes from meetings detailed discussions and actions taken. Minutes were available for people to access if they wished and included feedback from people regarding activities and menus.

A complaints policy and procedure was in place and displayed in the entrance area. Copies were also given to people as part of the information given on admission. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. Complaints had been responded to in accordance with the organisations policy and procedure, with details of correspondence included. The manager understood the importance of ensuring even informal concerns were documented to ensure all actions taken by the service were clear and robust. Concerns raised had been documented along with actions taken to resolve them. Everyone we spoke with told us the manager had an 'open door' policy and people confirmed they would be happy to raise any concerns with the manager if they needed to.

Requires improvement

Is the service well-led?

Our findings

There had been a number of recent changes to the management and the acting manager had only been in post for a short time. Staff were generally positive about the way the service was now being led telling us, "It's well organised and easy to work here. We get support and the manager is very good and is very fair in making decisions." And, "I am very happy here there is good support from the manager and head of care." However, further staff felt that communication could be improved and told us they did not always feel listened to. We were told, "We don't know what the manager is aware of, we need a way of letting them know when we are short staffed or something needs to be bought to their attention." We discussed this with the acting manager who told us they would look at implementing a way for staff to feed back information to facilitate communication between staff and management.

The acting manager demonstrated a clear understanding of their role and responsibilities with a real emphasis on always putting the person first and foremost. The manager worked full time at the home and told us they worked varying hours to ensure they had a clear picture of how the home ran at all times. Despite only being in post a short time, the acting manager demonstrated a good knowledge and understanding of people, their needs and choices. They told us their aim was to ensure the service was open and transparent and welcomed comments and suggestions from people and staff to take the service forward and make continued improvements. The acting manager told us that they were making changes and implementing new ways of working.

The acting manager was aware that the changes to management had caused some anxiety amongst staff and felt that this was improving as people got to know them. The acting manager had implemented a number of changes and had identified further areas of improvement. Some of these had not yet commenced but they were able to show us documentation and discuss with us how these changes would be implemented. There had been a clear improvement in staff sickness levels and the acting manager was looking at a more effective staff mix to ensure less experienced staff were supported by more experienced members of the team. Although positive, these changes were yet to become fully embedded into practice.

When people moved into the service an initial assessment was completed. After 72 hours their care documentation was audited to ensure it included all information and care requirements. The manager felt that any feedback was valuable to ensure that people were happy with everything or if there was anything they wanted done differently. Questionnaires were also given out to people and staff to gain feedback. The results of these were analysed by the head office and a report sent to the home. The acting manager then completed any actions and detailed these showing how these had been taken forward.

Quarterly residents and relatives meeting had taken place, we saw that relatives had been sent invitations to attend, and the acting manager told us that they also kept in touch with families via email. A resident's survey had been sent out to people in the last month, results were analysed then sent back to the service by the head office to ensure the acting manager was aware of any comments and improvements to ensure these could be addressed in a timely manner.

There was a system in place to assess and monitor the quality of the service. However, we found shortfalls, for example, areas of documentation including end of life care, daily records and charts were not always up to date. This was an area that required to be improved.

Audits taking place included weekly, monthly and quarterly audits, reviews, health and safety checks and annual policy reviews. This included care delivery and documentation, environment and infection control, medicines, kitchen, maintenance, domestic services, nutrition, accidents, incidents, falls and safeguarding. All auditing completed at the service was checked and reviewed by the acting manager and then fed back to BUPA head office for analysis. Reviews completed were compared to previous months data to ensure issues had been addressed and followed up appropriately. If this had not happened the issue would be raised with the person responsible for completion. A number of quarterly and annual audits were completed by the area and quality managers who visited the service. This included a 'CQC' style audit to ensure regulation was met. The response was proactive, any areas which needed to be addressed were noted promptly and actions taken to rectify or improve.

Staff meetings had taken place. Minutes were available and all staff were asked to read and sign these to ensure everyone was aware of information discussed.

Requires improvement

Is the service well-led?

Policies and procedures where available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. The acting manager and provider had a good understanding around 'duty of candour' and the importance of being open and transparent and involving people when things happened. The acting manager told us that they were always keen to learn from incidents to improve future practice.

Staff were aware of the policies and were aware that these underpinned safe practice. Policies and changes to procedure were discussed during meetings to ensure everyone was aware if changes occurred.

All of the registration requirements were met and the manager ensured that notifications were sent to us and other outside agencies when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured people received safe care and treatment with regards to medicines.** Regulation 12 (1)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured service users were treated with dignity and responded to in a caring and compassionate way at all times.** Regualtion 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were available at all times to meet people's care and treatment needs.** Regulation 18(1)