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# Polefield Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This unannounced inspection took place on Wednesday 19 April 2017. We returned to the home to complete the inspection on Monday 24 April and this was announced in advance of our visit.

Polefield Nursing Home  provides 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 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, 35 people were living at the service.

Our last inspection of Polefield Nursing was in October 2016 where the service was rated overall as 'Requires Improvement' and in four of the five key questions against which we inspected. These included Safe, Effective, Caring and Responsive, with Well-led rated as 'Inadequate'. There were three breaches of the regulations identified at that time with regards to safe care and treatment, good governance and staffing. This inspection was carried out to ascertain whether improvements had been made since our last inspection.

At this inspection in April 2017, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, meeting nutritional and hydration needs, safeguarding people from abuse, good governance and staffing. We are currently considering our enforcement options and course of action.

At the time of the inspection the home did not have a registered manager in post. This meant the service were failing to comply with the requirements of their registration. 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.

People were not safe as they were not protected from the risk of aspiration. People assessed as being at risk from an 'unsafe swallow' were given foods by staff which could cause them to choke or aspirate. Some of these had been listed as foods to avoid when they had been referred to SALT (Speech and Language Therapy). The supplement 'Thick and easy' was also left accessible around the home which presented the

risk of people consuming this accidently and placing themselves at risk.

We found the kitchen area was left unsupervised early in the morning when we arrived at the home, with large kitchen knives and a boiling hot water dispenser accessible to people living at the home. The risk assessment implemented following our first inspection visit was not followed and control measures were not adhered to which placed people at continued risk of harm.

Medication was not always given to people safely and we found instances where people had not received their medicines as prescribed. PRN (when required) protocols had still not been implemented which had been raised as a concern at our previous inspection visit.

People living at the home said they felt safe and staff had a good understanding about how to report any safeguarding concerns.

Staff recruitment was robust, with appropriate checks carried out before staff began working at the home.

The building and necessary equipment such as hoists were maintained regularly, with certificates of work completed held in an organised file.

We identified gaps in staff training in areas such as infection control, safeguarding dementia awareness, fire safety and health and safety. The manager was in the process of ensuring staff had access to appropriate equipment such as laptops, to be able to undertake this training during quieter periods of their working day.

People were not always protected from the risk of losing weight and we identified two people whose food was not being fortified with additional calories as advised by the dietician service following referral. There were also concerns with the recording of weekly weights and people being offered snacks in between meals. These measures could have helped peoples weight to increase over time.

The home was not working in accordance with the MCA (Mental Capacity Act). For instance, we found staff at the home did not carry out assessments of peoples capacity when they had been identified as having a severe cognitive impairment. One person was asking to leave the home during the inspection and in this case, an MCA assessment had been carried out, however an appropriate DoLS (Deprivation of Liberty Safeguards) referral had not been made. This meant people were being detained without lawful authority.

We saw evidence of supervision and appraisal being undertaken, with a staff induction programme in place to support staff in their roles.

Due to the wide spread failings found within the service, people living at the home did not always benefit from a caring culture. This was in relation to people being at risk of choking and weight loss due to recommendations not being followed and legislation not being followed when people lacked the capacity to make their own decisions.

The feedback we received from people living at the home was that they received a good level of care and they were happy. We saw staff treating people with dignity and respect and promoting people's independence where possible.

We found accurate and contemporaneous records were not always maintained. This included re-positioning charts, weight monitoring, oral hygiene, nail care, fluid consistency and life history information for people living at the home.

There were systems in place to investigate and respond to complaints appropriately. The people we spoke with said they would speak with staff or the manager if they were unhappy with the service they received.

There were also systems in place to seek feedback from people living at the home and their relatives. This included residents/relatives meetings and satisfaction surveys. The results of these were then analysed, with action plans put in place to drive improvement.

The systems in place to monitor the quality of service being provided were ineffective. For example, there were no governance systems to monitor nutritional intake, people at risk of weight loss, staff training and MCA /DoLS. These had been some of the areas of concern that we identified during the inspection. There were also continuing breaches of the regulations and a failure to improve the overall rating of the home.

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, we 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.

## 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.

People at risk of choking did not always receive specialised diets which had been advised by SALT (Speech and Language Therapy), meaning there was a risk of aspiration. We found the supplement 'Thick and Easy' was left accessible to people at the home meaning there was a risk this could be consumed unsafely.

The kitchen was not secure with items such as large kitchen knives and boiling hot water dispensers easily accessible to people which could have placed them at risk.

People did not always receive their medication as prescribed.

### Is the service effective?

**Inadequate**

The service was not effective.

People deemed to be at risk of losing weight did not receive meals that were higher in calories which had been advised by the dietician service. This could place them at risk of further weight loss. Weekly weights and giving people snacks between meals was not carried out as requested.

We still identified gaps in staff training which had been highlighted at our previous two inspections.

MCA (Mental Capacity Act) assessments were not carried out when people were deemed to have severe cognitive impairments and DoLS applications were not always made when people lacked capacity.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Due to some of the serious concerns identified during the inspection, people did not always benefit from a caring culture.

The feedback we received from people living at the home was

that they received a good level of care.

People had their privacy and dignity respected, with staff promoted their independence where possible.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Record keeping was poor in relation to personal care records, care plan information and details about peoples life history, likes and dislikes.

There were systems in place to investigate and respond to complaints appropriately.

There were also systems in place to seek feedback from people living at the home and their relatives. This included residents/relatives meetings and satisfaction surveys.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was no registered manager in post, meaning the service were failing to comply with the requirements of their registration.

We found three continuing and two additional breaches of the regulations. There had also been a failure to improve the overall rating of the service.

The quality assurance systems in place were not robust and had failed to identify the concerns we had found during the inspection.

# 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 19 and 24 April 2017. The inspection team consisted of two adult social care inspectors from the CQC (Care Quality Commission).

In advance of our inspection we liaised with external stakeholders based at Manchester City Council. This included the local safeguarding, infection control, and contracts/commissioning teams. We also contacted Manchester Healthwatch, although we did not receive feedback from all of the agencies we contacted.

As part of our inspection planning we reviewed all the information we held about the home. This included previous inspection reports, enforcement notices and notifications sent to us by the home including safeguarding incidents or serious injuries.

At the time of the inspection there were 35 people living at the home. During the day we spoke with the manager/provider, deputy manager, administrator, the cook, the activities coordinator, six people living at the home, two relatives and seven care staff. This included both nurses and care assistants. As part of the inspection, we looked around the building and viewed records relating to the running of the home and the care of people who lived there. This included 12 care plans, five staff personnel files and eight medication administration records (MAR).

We spoke with people in their bedrooms and communal areas, as well as observing how staff cared for and supported people living at the home. We also observed lunch being served in the dining room of the home on both days of the inspection to see how people were supported to eat and drink.

Inadequate

# Our findings

During the inspection we asked people living at Polefield if they felt safe. A person told us; "I feel safe. It's alright here. I'm looked after". Another person said to us; "The home is safe. I like going for a smoke outside and the staff stay with me whilst I mobilise". A third person added; "I do feel safe. I had deteriorated previously but I am slowly getting back on track".

We found risks to people were not appropriately managed, which had exposed people to significant risk of avoidable harm. We were informed by staff there were people living at the home that had been assessed by SaLT (Speech and Language Therapy Team) as having an 'unsafe swallow'. The SaLT had undertaken an assessment with people to determine the consistency of food and drink that people required in order to mitigate the risk of the person choking or aspirating. Aspirating is when food or drink goes down the windpipe and enters the lung.

We saw people's care files contained SaLT guidelines, which detailed the person's dietary needs. For example, whether the person required a diet that was considered 'fork mashable' or pureed. It also advised the recommended consistency of drinks such as syrup or custard consistency; and outlined the foods staff were to avoid giving the person in order to maintain their safety. During this inspection we identified serious concerns in this area.

We observed one person eating their breakfast in the lounge on the nursing unit. We noted they were eating a pureed diet, which had been advised by SALT. We looked at the person's care plan and saw it was documented that the person should be supervised when eating, so signs of coughing when eating and drinking could be observed. We saw this person was eating unsupervised and they were coughing and spluttering when consuming their food and drink. A member of staff walked through the lounge and saw this but they just told the person to 'take their time' and left the room. This placed the person at risk as staff were not following the care plan.

We looked at eight care files of people who had been assessed by SALT. We saw in one person's nutrition and food care plan they required a fork mashable diet and syrup consistency drinks. However, we could not find the associated SaLT recommendations in the person's care file for staff to follow. We also noted a second person had SaLT recommendations in their care file detailing they required a fork mashable diet but the care plan information contradicted the SaLT recommendations and stated they had no dietary needs and their foods were of normal consistency.

We asked the staff how they managed people's specialist dietary needs. They said the chef had a list of people's requirements and they prepared the food, which staff served to people from the food trolley. We looked at the chef's list but we found some of the people that had SaLT recommendations in place were not on the chef's list.

The SaLT guidelines held within care plans provided a list of 'foods to avoid' to ensure people were not placed at risk of choking and aspirating. This included; fruit and vegetables such as grapes, tomatoes and peas. Pastry, dry toast and biscuits were also identified as foods not recommended for people assessed as having an 'unsafe swallow'. We looked at eight people's food and fluid records and saw that all the people we had tracked had received foods that were not recommended. We saw pork pies, quiche, meat pies, grapes, peas, toast and biscuits were frequently documented as having been given to these people. We also observed a staff member give a person three biscuits when their SaLT recommendations advised against this.

The care plans of these two people had also not been updated to capture these recommendations and ensure staff had up to date information. For instance, 'Foods to avoid', which had been advised by SALT had not been added to care plans to make staff aware of the risks. This again, could have place these people at risk of choking on their food.

We saw staff followed the SaLT recommendations regarding the consistency people required their drinks but we found the supplement used to thicken people's drinks known as; 'Thick and Easy' was not stored safely. A patient safety alert had previously been issued by the NHS due to this supplement being consumed unsafely, which had caused a person to choke and die.

On the first day of our inspection, we found thick and easy stored in unlocked cupboards in the dining room. We informed the management of our findings following our first visit and requested that this was addressed. However, on the second day of our inspection we found thick and easy left unattended with the lid removed on the drinks trolley. This meant people were exposed to significant risk of harm.

We saw the kitchen could be accessed from the lounge on the nursing unit. We arrived at the home at 07.00 to undertake both inspection visits and found the door was unlocked with no staff presence to prohibit people accessing the kitchen. The door had been left wide open and there was a boiling hot water dispenser located immediately to the right of the door. There were also large kitchen knives hanging on the wall. We asked if there was a risk assessment in place, detailing any control measures as to how these risks were mitigated. We were informed by the manager that there wasn't one in place at that time. On our second visit, we saw a risk assessment had been conducted which detailed the control measure was to ensure the kitchen door was locked. However, during our second visit we observed the door being left open. This meant the guidance was not being followed as the kitchen remained unlocked and the knives were still on the wall. This meant people continued to be exposed to the risk of burns, scalds and serious injury.

We looked at medicines management within the home and saw detailed policies and procedures in place. We looked at eight Medicine Administration Records (MARs); five on the residential unit and three on the nursing unit. We saw the MAR contained the person's photograph and documented the person's allergies. Following our first inspection visit, we gave feedback to the provider and at our second visit we saw the MAR had been strengthened. The MAR had been updated to include a safety summary which detailed whether the person had a safe or unsafe swallow, the person's dietary requirements and consistency of their drinks, whether the person required observation taking medicines or covert medicines and if the person took non-prescription medicines.

Medicines were stored safely and securely. Keys for both the store rooms and medicines trolleys were kept with the responsible person allocated to administer medicines and the medicines trolley was locked between administrations. A body map was completed to identify where creams were to be administered and a separate record was maintained by the care staff to demonstrate they had been administered. Creams were stored out of view in people's drawers and steroid based creams were stored in the treatment room.

During observation of the medicines round we noted the senior support worker was patient and caring. We saw the time medicines were administered was not documented on the MAR but we noted the senior support worker took into account the time the morning administration finished when commencing the administration of the lunchtime medicines. However, we found there was no system in place to administer all the medicines per prescriber's recommendations. Some medicines that needed to be given before food, such as medicines to reduce gastric acid, hormone replacements and antibiotics we observed being given after people had eaten their breakfast.

We also found there was no information recorded to guide staff when administering medicines ,which were prescribed to be given 'when required' (PRN); this included medicines prescribed for anxiety, pain and constipation. There was no information available to guide staff when a variable dose of medicine was prescribed to support staff to administer the most appropriate dose of medicine. The MAR had a section on the reverse to enable staff to document the exact time PRN medication had been given but we saw PRN was not consistently being documented on the reverse of the record when administered. This meant the provider could not demonstrate sufficient time was maintained between doses, why the medicines had been administered or if the PRN had been effective to provide a clinical picture. This exposed people to the risk of their medicine not being given consistently and people could experience unnecessary discomfort as a result.

We noted that stock balance checks were completed to ensure medicines were ordered in sufficient time. However, we noted a person living at the home had been due a prostate injection four days prior to our second inspection visit. The records indicated that the injection had not been administered so we asked the nurse to confirm that this was not just an administrative omission. The nurse was unable to determine this from the records and had not noticed this prior to our enquiry. The nurse was proactive in addressing this and contacted the GP who confirmed that it had not been administered. Missing this for a few days shouldn't cause an adverse effect. However, if missed for longer than a few days the body could start to produce testosterone which could result in the cancer growing again.

Due to the concerns we identified in relation to management of medication, people at risk of choking, storage of thick and easy and the kitchen not being secure meant there had been a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

We looked to see how accidents and incidents were monitored and whether control measures were implemented to reduce the risk of re-occurrence. We saw that falls were monitored and triggers or trends were identified and evidenced. We saw learning from incidents or investigations took place and appropriate changes were implemented, including the action taken to minimise the risk of further incidents. Accident/incident forms were completed in people's care file and an accident, falls, observation record was completed. The information captured the nature of the accident, incident, date, time, location, contributing factors, injury and the action taken. A monthly falls analysis was undertaken and what had occurred as a result was documented. For example; bed sensor in place, or referral to the GP for medicines review or O/T for a mobility assessment.

We looked at the system in place to safeguard people from abuse and improper treatment. There was a safeguarding policy in place and staff understood the procedure to follow if they felt that people might be at risk of abuse or harm. The staff members we spoke with described what action they would take if they had concerns about people's safety. The staff members could describe the signs and behaviours they would look out for that would alert them to the possible consequence of abuse. One member of staff said; "Abuse could be physical, institutional, neglect or emotional. I would report any concerns I had about a person to the nurse in charge". A second said; "We get face to face safeguarding training. We get to know people personally so we would know if something was different. Abuse could be physical, mental, financial. I'd report to the senior. I've confidence they'd report to the authority but if not I'd ring CQC". A third member of staff added; "Safeguarding is about protecting people from harm and abuse. This can occur in the form of sexual, financial and mental. People being in a low mood, out of character and generally not being themselves could be signs of abuse".

We looked at five staff personnel files and saw that staff had been recruited safely and the required recruitment checks had been carried out prior to them starting work at the home. Staff had produced evidence of identification, had completed application forms with any gaps in employment explained, had provided employment references and a Disclosure and Barring (DBS) check had been undertaken. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

During the inspection, we looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs. We were told staffing levels were calculated based on the 'Isaac Newton' dependency assessment, which we saw had been completed in people's care files to determine the degree of people's dependency on staff to provide support. The provider told us that an analysis was done on this information, which determined the care hours required to meet people's needs. We were told the information was analysed quarterly to determine the home's staffing levels. We asked to be shown the calculation for the previous quarter so we could cross reference this with the off duty for that period. We were informed that the admin member of staff was not in that day and that the provider did not have access to this information. We noted from the off duty that the staff ratio did not change and this was confirmed by staff. We were consistently told there was a senior and two carers upstairs, which reduced to two staff at weekend. The nursing floor had a nurse and two care staff and a floating member of staff went between both units providing support as and when required.

We asked staff if they felt there were sufficient numbers of staff deployed to meet people's needs. A staff member told us; "I feel there are enough staff. We meet people's needs". A second said; "There are enough staff. Having the floater to support between both floors is a big help. It's more relaxed at weekends so we don't need the same number on". A third member of staff added; "Sometimes we can be limited in being able to spend time with people, but we are able to get things done".

Although we saw evidence of people's care needs being met in a timely way, we recommend the home carries out a further review of the dependency assessment, to ensure consistent numbers of staff are available to safely meet the needs of people living at the home.

We saw that regular checks of the building and maintenance of equipment was done to ensure they were safe for people to use. This included servicing of the nurse call system, the lift, hoists, legionella, portable appliance testing, electrical installation, gas, fire safety and extinguishers.

We found the service had a file containing personal emergency evacuation plans (PEEPS) for each person living at Polefield nursing home. The PEEPS provided details regarding the person's assessed abilities in the

event an evacuation of the home was required. It also contained floor plans for both the nursing and residential floors, showing where the fire escapes were as well as the 'safe zones' in the event of a fire. The service also had a business continuity plan in place, which provided details about actions staff needed to take in the event of an emergency. We found one person had two PEEPS and there was conflicting information detailed which could lead to confusion regarding the person's support requirements in the event of an emergency. We informed the provider of our findings following the inspection and they assured us that the PEEPS would be looked at to ensure only the relevant information remained in the file.

Inadequate

# Our findings

People living at the home and their relatives told us they felt staff were sufficiently trained and had the correct skills to provide effective care. One person said; "They are good are these staff and seem to have good training". Another person added; "All the staff are spot on and I can't fault any of them".

We looked at how the home supported people to maintain good nutrition and hydration and asked people for their opinions of the food available at the home. One person said; "The food is alright and I would definitely say it is tasty". Another person said; "The food is okay and seem to be good quality. There is a choice as well". A third person added; "The food has been good since I have lived here".

We found staff at the home had been proactive in referring people to other healthcare professionals such as dieticians when they were deemed to be at risk of losing weight. The dietician service then visited the home and implemented action plans with guidance for staff to follow, however we found that this advice was not consistently followed, which could place people at further risk of weight loss. During the inspection we reviewed the care plans of two people who had experienced weight loss since living at the home. The dietician service had advised that staff undertook specific tasks such as fortifying foods with milk, butter and cream, as well as offering regular snacks between meals and monitoring the weight of these people on a weekly basis.

We spoke with the chef to ascertain how this information was communicated to them to ensure these actions were acted upon appropriately. We asked how the food prepared in the kitchen was fortified with additional calories and if this was done for individual portions, or the entire batch of food prepared. We were told only individual portions were fortified, however we found this was only being done for two people and these were different to the people we had identified as experiencing weight loss and had dietician recommendations in place. A list of all the people living at the home with specialist dietary needs had been implemented by the second day of the inspection. However, one of these people had again been omitted from the chef's list.

One of these people was admitted to the home weighing approximately 43 kg (kilograms) at the end of November 2016. They continued to lose weight throughout February 2017 where they were weighed as low as 38 kg. The second person was also referred to dieticians in February 2017 due to weight loss and reduced dietary intake. The letter from the dietician advised they had lost approximately seven pounds between December 2016 and February 2017 and weighed 60kg when they were referred. At the time of the inspection, this person's weight had continued to slowly decline where it had been recorded as 58 kg.

We checked the food intake records of both of these people and found that snacks in between meals were not being recorded as either consumed or offered/declined in line with guidance from the dieticians service. There were also gaps in the weekly weight recording for one of these people. One of these people said to us during the inspection; "I get my supper at night but I don't usually get offered things in between meals to eat".

This meant there had been a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Meeting Nutritional and Hydration needs.

We checked to ensure staff sought people's consent prior to providing any care interventions. We observed this was consistently done by staff. For example, we heard staff asking people if they were ready to take their medication or if it was okay for them to be transferred from the lounge to the dining room in their wheel chair. The care plans we looked at also contained signed consent forms indicating people's agreement with care plans, risk assessments and photograph's which were signed by either people living at the home, or their relatives. A person living at the home commented; "The staff do ask what I want and what I like".

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. 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 those applications had been submitted, or were still pending with the local authority waiting to be granted. We saw that people had capacity care plans in place and we noted that three people in particular had been assessed as having severe cognitive impairments and were not able to make decisions for themselves. For two of the people, MCA assessments had not been undertaken. For the third person, an MCA assessment had been done, with the person being deemed to not have capacity. Despite this, a DoLS application had not been made. This person was heard saying that they wanted to go home during the first day of our inspection. Another person had a DoLS in place which needed to be re-applied for in early April 2017, however this was not done until we raised it as a concern during the inspection.

This meant people were being deprived of their liberty without lawful authority. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safeguarding service users from abuse and improper treatment.

We looked at the induction, training, supervision and appraisal staff received to support them in their roles effectively. When staff first started working at the home they undertook an induction, which provided them with an overview of working at the home. We saw this provided a focus on manual handling, health and safety/accidents, rotas/sickness absence, customer service, confidentiality and the call bell system. One member of staff said; "I did receive an induction and felt it was sufficient for what I needed". Another member of staff said; "I had a weeks induction and covered the main training areas needed before providing care; safeguarding, moving and handling".

We saw staff supervisions were undertaken, with the most recent ones done in March 2017. The topics of discussion included resident's safety, person centred care, feedback from residents, safeguarding, team

working, training and personal development. Appraisals had also been conducted in April 2017 and provided an oversight of the past 12 months, strengths/weaknesses, performance, objectives and areas for improvement. A member of staff commented; "We do have supervision and they are done quite a lot". Another member of staff said; "I only started in March but have had a supervision already".

At our previous two inspections in April and October 2016, we identified gaps in staff training in areas such as fire safety, infection control and safeguarding. We found this to be a continuing area of concern at this inspection. We found the home maintained two training records, with one covering e-learning and the second for any practical sessions completed by staff. We were told both were up to date. The practical matrix had 40 members of staff listed, with the percentage completion rates detailed at the top of the page. However, only 68% had completed safeguarding training, with only 51% having completed training relating to infection control. Additionally, only 24% had completed training relating to Health and Safety and only 33% had completed training relating to moving and handling.

The e-learning matrix listed 42 members of staff. However only 27 had complete moving and handling, 13 had completed infection control, 16 had completed fire safety and 23 had completed safeguarding. The other courses where training gaps were identified included food safety and dementia awareness. There had also been no training provided to staff in areas such as choking and dysphagia, which was an area during the inspection where we identified significant concerns. This meant not all staff were being provided with sufficient training to support them in their roles. The manager told us there had been difficulties getting staff to complete some of the training, with issues such as limited access to IT equipment being a contributing factor for some staff. We were told several laptops would be available at the home, where staff could complete these sessions when they had free time during their shift.

This meant there had been a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Staffing.

Requires Improvement

# Our findings

The people living at the home told us they were happy with the care they received. One person who used the service told us; "I receive good care. The home is clean and tidy and the staff are great. They all seem to be nice with me. I'm quite satisfied overall and have no concerns". Another person said; "The care is okay and I feel I am being well looked after". Another person said; "I haven't been here long but have found the service to be very good". A fourth person added; "They can't do enough for me here, they are fantastic". A relative added; "The staff are lovely. We are made to feel very welcome".

We found there were widespread and significant shortfalls in the home, which meant people's immediate and on going needs were not consistently met to demonstrate a caring culture. Whilst we found some staff had good intentions, they were not supported by the overall management or systems in the home to ensure that people were kept safe For example, people with nutritional needs were left unattended when eating which could have resulted in significant harm to the person.

We observed pleasant interactions between staff and people living at the home. For instance we observed a member of staff sat with one person at breakfast. They had their arm around them and were gently encouraging them to eat their food as well as encouraging them to have a drink and praising them that they were doing well. They were also chatting about the person's family and if they had been to visit recently. At one point, music was playing in the dining room. Staff encouraged people to sing along if they knew the song and we saw people laughing in response which they enjoyed.

We saw people were also given choice by staff about how they wanted their care to be delivered. For instance, we saw a person being offered the choice of either hot or cold milk with their cereal. People were also offered two choices at meal times and were able to select from the menu. Additionally, we saw people being asked if they would like to eat their meals in either the dining room or lounge area. Another person requested bacon on toast for breakfast. The staff rang this down to the kitchen and it was accommodated. Another person was made an omelette and the chef had purchased them a jar of large pickles they had requested. This showed that staff considered people's choices and respected their decisions and choices.

We observed throughout the inspection that people's relatives were able to visit without being unnecessarily restricted and there were no prescriptive visiting times at the home. We also observed and were told about some positive examples of how staff demonstrated that they cared for people living at the home. One person told us a carer was attending a relative's wedding with them so they could go as their family would be unable to take responsibility for them and their needs. The person was visibly excited about the

upcoming event. We were also told of a staff member who gave a person a patch work quilt to cover their legs when they went out in their wheelchair because they'd mentioned their legs were cold when they'd been out.

We saw evidence that staff displayed a good understanding of people's needs. We observed a staff member go in to a person's bedroom as soon as they heard the person was shouting out. The staff member told us that we would have to wait a minute because the person would be upset if they didn't have a cup of tea now that they had woken up. We saw staff calm a person that was agitated by looking at family photographs with them and speaking to them about their grandchildren. Staff were observant to people's needs. We saw the staff member approach a person and enquire whether the person was experiencing discomfort. The staff member offered the person pain relief and sat with them giving reassurance and comfort.

We saw staff treating people with dignity and respect. Staff knocked on people's doors and waited to be invited to enter the person's room. We saw staff were discreet when supporting people with personal care and closed doors. Staff told us how they maintained people's dignity when undertaking personal care tasks. One member of staff said; "I always make sure curtains and doors are closed. If people have dressing gowns, make sure they have them with them so they are covered".

We saw that where possible, staff promoted the independence of people living at the home. This included allowing people to eat their food and drink themselves and mobilise around the home with the support of a zimmer frame. One person living at the home said; "The staff let me do things myself as long as I am able to". Another person said; "I can have a wash myself and the staff know that so they let me".

Requires Improvement

# Our findings

We asked people and their relatives whether people living at the home received care that was responsive to their needs. People told us; "I do what I want, when I want and they accommodate that". Another person said; "My opinion is that I get everything I need and that my care needs are met". A third person added; "I would definitely say the staff are responsive to what I want".

Throughout the inspection we found that record keeping was poor. This was in relation to weekly weight checks, turning/re-position charts, fluid consistency, oral hygiene and nail care. Contemporaneous records on the upstairs residential unit were also not maintained, with records placed in to the filing cabinet without being filed in order, which meant records were hard to locate. Therefore it was difficult to establish if necessary care interventions were being carried out by staff.

There were inconsistencies in the care files we looked at in regards to how people's biographical history had been captured. People's likes and dislikes, personal preferences and hobbies were not consistently identified by the provider to support staff to plan care and treatment. We saw only one person had a personal fact sheet but this did not contain information regarding the person's preferred pastimes or hobbies.

We saw care plans provided information about supporting people with maintaining a safe environment, activities of daily living, personal care, skin integrity, nutrition, continence, breathing, mood, decision making, perception, memory, communication, social interaction and mobility. The care plans we looked at were not consistently person centred, although we saw attempts had been made to improve this and work was underway to address this. The care plans did not reflect person-centred goals or identify goals that were individualized, measurable and achievable.

We found it was unclear from people's care files who had capacity to agree to their support. We saw one person had been involved in reviewing their care and two people's families had signed to say that they agreed with the content of the care plans. We found inconsistencies in the documentation in the care files to determine that people had consistently been engaged with this process.

We informed the provider of our findings and they acknowledged this deficit and indicated that strengthening care plan documentation and person centred planning was the next phase of the service improvement plan that had already been identified internally. The provider told us they already had a template of how the care files would look which they intended to transfer from another home in the

providers portfolio and roll out at Polefield nursing home.

The failure to maintain accurate and contemporaneous records was a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 with regards to good governance.

We looked to see how the service managed people's pressure care. We saw assessments were completed and noted the staff were consistently exceeding people's recommended fluid intake, which supports good skin integrity. When people had been identified at risk, we saw that people were seated on pressure relieving cushions and had profile mattresses to provide a reduction in pressure on vulnerable areas such as heels and the sacrum.

We looked to see how people were provided opportunities to engage in social stimulation and activities of their choosing. The home employed an activities coordinator for 25 hours a week who was extremely passionate about their role and meeting the individual needs of people living at the home. The activities coordinator was undertaking an NVQ (National Vocational Qualification) and had changed some of their modules to meet the needs of the role, such as; provision for journeys and activities coordination.

We saw the activities coordinator encouraging people to take part in activities throughout the day and also respecting people's choice if this wasn't what they wanted to do. A person told us; "I'm not interested in activities, I've never been a good mixer but that's my choice. They respect that". A second person said; "There is enough to do. There is something going on everyday".

The activities coordinator had activities scheduled on a board which included; exercises three times a week, bingo, hairdressers, one to one's with people, play cards right, sing along, exercises, quizzes, arts and crafts. We spoke to the activities coordinator who told us the schedule was flexible depending on people's motivation and preference on the day. The activities coordinator maintained a list of activities that had been undertaken and were planned for people. People were in the process of applying for bus passes so they could utilise ring and ride to access the community. We saw entertainers and choirs were also scheduled at the home.

We saw residents' meetings had taken place at the home, with the last one being in February 2017. An agenda was in place, with topics of discussion including food/menus, laundry, activities and any other items people wanted to discuss. Relatives' meetings had also been held where things such as the last CQC report, refurbishments, quality of care and the environment had all been discussed. This meant both people living at the home and relatives were being given the opportunity to contribute towards how the home was run.

People living at the home had also been asked for their views and opinions through the use of a satisfaction survey. This asked if they felt treated with dignity and respect, felt safe and secure, if care was being provided to a high standard, if complaints were taken seriously and if the activities provided were sufficient. An overall analysis of the feedback was then undertaken, with an action plan completed where any negative comments had been made.

We saw the complaints process was advertised on numerous walls throughout the home. There was a complaints file in place to track complaints and people we spoke with confirmed they were aware of the process and felt confident to make a complaint. One person said; "The care is good, I've no complaints. I would talk to staff if I had". A second person said; "I've no concerns or worries. They keep good order".

Inadequate

# Our findings

At the time of the inspection the home did not have a registered manager in post. This meant the service were failing to comply with the requirements of their registration. 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.

There was a staffing structure in place. The registered provider is a partnership, first registered with CQC in November 2015. One of the partners is also currently the home manager. The manager told us that due to recent issues and concerns at the home, there had been difficulties recruiting someone on a permanent basis to the role. The other staff employed at the home included a clinical lead, staff nurses and care assistants. In addition, there was a deputy manager, an administrator, activities coordinator, a maintenance person and both domestic and kitchen staff.

At our first comprehensive ratings inspection of Polefield Nursing Home in April 2016, the home was rated overall as 'Inadequate', with breaches of the regulations identified. We carried out a further comprehensive inspection of the home in October 2016, however found continuing breaches of the regulations relating to safe care and treatment, good governance and staffing. The Well-Led key question remained as Inadequate at this inspection, however the overall rating was changed to 'Requires Improvement'.

At this inspection, we again identified continuing breaches of the regulations regarding safe care and treatment, good governance and staffing. We also found two additional breaches of regulations where standards had declined in relation to safeguarding people from abuse and meeting people's nutritional and hydration needs. This meant the home had been in breach of the regulations for approximately one year, with the overall quality of service failing to improve as would be expected.

We looked at the systems in place to monitor the quality of service provided to ensure good governance within the service. We saw that audits were undertaken of water temperatures, complaints, CQC notifications, building maintenance, medication, health and safety, care plans and the environment. We noted that findings were identified, with any follow up actions recorded. We did find however, that there were no quality assurance systems in place with regards to areas such as kitchen safety, people's dietary requirements, specialised diets, training, DoLS/MCA, weight loss and record keeping. These had been areas where we had identified concerns during the inspection. A more robust governance system should identify these concerns and allow the service to take appropriate action as a result.

The continued failure to monitor, assess and drive up improvements was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 with regards to good governance.

Staff told us morale was good and they were happy working in the home. We found there was a positive atmosphere within the home and the staff team were motivated and worked well together. One member of staff said; "I feel the management are approachable and I feel supported". Another member of staff said; "The manager has done a lot with the home since coming in. Improved the environment and is visible in the home". A third member of staff added; "We are a big family here. There is no arguing, we all get on and look out for each other. We get on with people's families too".

We asked staff about management and leadership at the home. One member of staff said; "It's okay most of the time, but I feel their could be room for improvement. I don't always feel listened to or appreciated. Some of us have been asking for new uniforms for a long time now but this seems to be being ignored". Another member of staff said; "I find the manager very helpful. If we raise concerns and issues then he seems to listen". A third member of staff added; "The manager is very approachable and seems to be good for this establishment. He seems to be on the same level as the staff".

We found that regular staff meetings were held at the home, with meeting minutes maintained. During the inspection we looked at the minutes from December 2016 and March 2017. Topics for discussion included infection control, personal care charts, training, menus, staff uniforms and any other issues staff wanted to discuss. A member of staff said to us; "I was unable to make the last one but they do take place. We are able to discuss issues and raise any concerns we have". Another member of staff said; "They are about every six months. We all voice our opinion and plan things out".

We found improvements had been made to the storage of confidential information. For example, at the previous inspection we had found filing cabinets containing people's care plans were left unlocked meaning they could be accessed by anybody in the building. At this inspection, we saw staff were vigilant in this area and took extra care to make sure records were stored away and cabinets were locked. Additionally, when we had viewed care plans in the lounge area, staff constantly checked if they were finished with so that they could be moved from areas where other people were present. This meant people's private information was being stored securely as required.

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 found the service was notifying us of all incidents as required.

The home had the necessary policies and procedures in place. These were available in the office and provided guidance in relation to complaints, confidentiality, DoLS, equality and diversity, safeguarding and whistleblowing.

At our last inspection, we issued the provider with a fixed penalty notice for failing to display the ratings from the previous inspection, which the provider subsequently paid. At this inspection we saw the ratings were displayed in the reception area. This meant both people visiting and living at the home knew about the CQC rating and the assessed quality of the service being provided and any concerns that had been identified.

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There were ineffective systems in place to ensure people received safe care and treatment. |

**The enforcement action we took:**

We issued a notice of decision to restrict admissions at the home. We also issued a notice of proposal to cancel the homes registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>There were ineffective systems in place to safeguard people from abuse. |

**The enforcement action we took:**

We issued a notice of decision to restrict admissions at the home. We also issued a notice of proposal to cancel the homes registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>There were ineffective systems in place to ensure peoples nutrition and hydration needs were met. |

**The enforcement action we took:**

We issued a notice of decision to restrict admissions at the home. We also issued a notice of proposal to cancel the homes registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 17 HSCA RA Regulations 2014 Good |

| | |
|---|---|
| personal care<br><br>Treatment of disease, disorder or injury | governance<br><br>There were ineffective systems in place to ensure good governance at the home. |

**The enforcement action we took:**

We issued a notice of decision to restrict admissions at the home. We also issued a notice of proposal to cancel the homes registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were ineffective systems in place to ensure staff received appropriate training to support them in their role. |

**The enforcement action we took:**

We issued a notice of decision to restrict admissions at the home. We also issued a notice of proposal to cancel the homes registration.