Akari Care Limited

Wheatfield Court

Inspection report

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Date of inspection visit:
05 June 2018

Date of publication:
13 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 5 June 2018. This meant the staff and provider did not know we would be visiting.

We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

At the last inspection in July 2017 the service was not meeting all of the legal requirements with regard to regulation 12, safe care and treatment, regulation 18, staff training and regulation 17, governance.

Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions about is the service safe, is it effective and is it well-led to at least good.

At this inspection we found improvements had been made and the service was no longer in breach of regulations 12 and 18. Although further improvements were required as identified in the inspection report. A breach of regulation 17 was in place as further work was required in order to achieve compliance. The quality assurance processes although becoming more robust required further action in other aspects of care. You can see what action we told the provider to take at the back of the full version of the report.

Wheatfield Court is a care home. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Wheatfield Court accommodates a maximum of 60 people who require nursing care or personal care, some whom may live with dementia or a dementia related condition. This includes a separate 'enhanced care facility' unit run by the NHS which provides temporary care and rehabilitation to up to 20 people who have been recently discharged from hospital or care to prevent their admission to hospital. At the time of inspection 53 people were accommodated at Wheatfield Court.

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

The provider undertook a range of audits to check on the quality of care provided. However, we considered some improvements were required with regard to record keeping, staff deployment, staff training and to ensure previous non-compliance was actioned in a timely way.

The environment was well-maintained and there was a good standard of hygiene. Improvements were required to ensure information was accessible to keep people involved and orientated.

Training provision had been improved for staff. However, we have made a recommendation that staff receive all available training, appropriate to their role to give them more insight into people's specific care and treatment needs. Staff were supervised and supported.

People and staff told us they felt safe and there were enough staff on duty to provide safe care to people. Staff knew people's care and support requirements. However, record keeping required some improvements to ensure it reflected the care provided by staff.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had access to an advocate if required.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Care was provided with kindness and people's dignity was respected.

Some activities and entertainment were available to keep people engaged and stimulated. Staff did not always interact and talk with people.

People were protected as staff knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People received an adequate and varied diet that suited their requirements. Systems were in place to ensure people's health needs were met.

People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. Communication was effective to ensure staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Improvements had been made to ensure people received safe care that met their needs.

There were sufficient staff on duty to provide safe care.

People received their medicines in a safe and timely way.

The environment was well-maintained and there was a good standard of hygiene.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff received supervision and some training to support them to carry out their role effectively. We have made a recommendation that staff receive training to give them more insight into people's specific needs.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet.

Improvements were required to ensure the environment promoted the orientation of people.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and cheerful.

Good relationships existed and staff met people's needs in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements had been made to people's care records but some other improvements were required to ensure they reflected the care provided by staff. Staff were knowledgeable about people's needs and wishes.

Staff in some areas of the home did not engage and interact with people except when they provided care and support. There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Work had been by undertaken the registered manager to achieve compliance with the regulations since the last inspection. However, we considered further improvements were required with regard to staff training, care records, staff deployment and the environment and orientation.

The registered manager and provider monitored the quality of the service provided and introduced improvements.

A registered manager was in place who encouraged an ethos of involvement amongst staff and people who used the service. Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Wheatfield Court

Detailed findings

Background to this inspection

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

This inspection took place on 5 June 2018 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and personnel from health authorities who provided health support to people.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 19 people who lived or were staying temporarily at Wheatfield Court, seven relatives, the registered manager, the area manager, the cook, kitchen assistant, two nurses, two clinical lead staff, six support workers, the activities co-ordinator and the housekeeper. We looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for four staff, seven people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

At the last inspection we had concerns that systems were not all in place for people to receive safe care and treatment. At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

A system was now in place to ensure that people who were at risk of pressure damage were appropriately supported. Staff carried out a daily check and recorded the settings of air flow mattresses that were used for people who were at risk of pressure damage. The check ensured that the air flow mattress was set at the correct pressure that corresponded with the person's weight. Charts had also been introduced for staff to record whenever they were carrying out a positional change with a person to reduce the likelihood of pressure damage to their skin. The registered manager showed us the new recording document that had been introduced by the company since the last inspection. However, we considered improvements were required to the document to capture all the checks carried out by staff with regard to pressure relieving equipment and to provide an accurate and accountable record. We discussed this with the area manager and registered manager who told us it would be addressed.

Other risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, mobility, choking and nutrition. The monthly evaluations included information about the person's current situation. Environmental risk assessments such as for the use of oxygen, fire, falls from windows and the kitchen environment were in place with a regular monthly review to ensure they remained accurate and reflected any current risk around the home.

Improvements had been made to the management of medicines. Guidance was available for staff that detailed when people may need 'when required' medicines, for example, for pain relief. Photographs were now available on people's medicines records reducing the risk of mistaken identity when medicines were administered by temporary staff. Topical medicines application records were in place that corresponded with prescription details, so staff had detailed instructions for the correct application of creams and ointments.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which

may be at risk of misuse.

People who used the service and relatives confirmed that they and their relatives were safe at the home. One person told us, "I was very lonely at home, I came here and they were all very friendly. I feel safe here, especially at night." Another person commented, "I am better off here. I get loads of help from all the staff." Other people's comments included, "I am comfortable here, I feel very safe", "I only have to press the buzzer and staff come", "I have a belt on my wheelchair which stops me sliding out" and "I am at home here and I feel quite safe." One relative told us, "[Name] is safe and settled here." Another relative commented, "We think [Name] is safe here, and we know [Name] feels safe here as well." A third relative said, "The staff are very protective toward [Name]. They are in a safe environment with people who care."

Our observations during the inspection showed, at current occupancy levels, there were sufficient numbers of staff available to keep people safe. Staff were not rushed and responded promptly and patiently to people's requests for support. One staff member commented, "Some days are busier than others but on the whole we have enough staff." There were 37 permanent people living at the home and 16 people staying on the 'step down unit' at the time of inspection. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely.

The two units that accommodated permanent people were staffed by two nurses and six support workers during the day. The 'step down' unit, was run in partnership with the NHS. It included a multi-disciplinary team of health and social care staff who were based on the unit and provided support to people on that unit. They included nurse practitioners, a liaison nurse, an occupational therapist, a speech and language therapist, a dietician and a rehabilitation assistant. A GP visited daily and there was input from consultant geriatricians. The core staff team available on the unit were one lead nurse and three support staff. Overnight staffing levels for the home included one nurse and six support workers.

Staff had undertaken safeguarding training about how to recognise and respond to any concerns. Staff we spoke with were able to clearly describe the appropriate steps they would take if they were worried about people's safety or wellbeing. Safeguarding records showed prompt referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Regular analysis of incidents and accidents took place. The registered manager told us accidents and incidents were monitored. Individual incidents were analysed and a monthly analysis was carried out to look for any trends. They told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

Arrangements were in place for the on-going maintenance of the building and a maintenance person was employed. All records relating to the maintenance and safety of the building and equipment were up-to-date and monitored. The environment was well-maintained. The building was clean and with a good standard of hygiene. One person told us, "There is a cleaner in my room every day, it is kept spotless." Infection control measures were in place to reduce the spread of infection. One relative told us, "The place looks brilliantly clean."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed regularly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Recruitment of staff was thorough. Appropriate checks had been undertaken before staff began working for

the service, including written references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Registration of nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

At the last inspection we had concerns that staff had not all received training specific to their job role. A system of regular supervision was not in place for all staff to receive support. After the inspection the provider sent an action plan to show staff would all have completed this training by December 2017. It was disappointing at the inspection to note this had not been achieved for all staff due to some circumstances beyond the registered manager's control. We received evidence after the inspection to show why this had not been achieved and the new planned dates for the identified outstanding training for staff and by the time of writing the report this training had almost been completed.

Outstanding training from the last inspection included fire safety, pressure area care, mental capacity and dementia awareness. Evidence after the inspection was provided to show that staff had completed fire safety training by the end of June 2018, relevant staff had completed pressure care awareness in June 2018. All staff would have received the dementia care and mental capacity training by the end of July 2018.

The staff training matrix showed that staff received other mandatory training and developmental training to give them some insight into people's care and support requirements. However, we considered further improvements were required to ensure all staff received this training that was relevant to their role and listed on the staff training matrix. For example, the staff training matrix, that the registered manager told us was up-to-date on 11 June 2018 showed from a staff team of over 60 staff members, that 23 staff members had not received distressed behaviour training, 44 staff had not received training about equality and diversity, 20 staff had not received end of life care training, 42 staff members had not received dignity training, 44 staff had not received training about continence and 13 members of staff had not received communication training. The area manager told us that this had been identified and was being addressed.

We recommend that staff receive available training, appropriate to their role to give them more insight into people's care and treatment needs.

A system of regular supervision had been put in place so staff received supervision every two months. The registered manager supervised the nurses and heads of department and the nurses supervised the support staff. This gave staff the opportunity to discuss their work performance and training needs. One staff member told us, "I get regular supervision." Another staff member commented, "I get supervision every six to eight weeks." A third staff member said, "Seniors do supervisions every two months." An annual appraisal took place with staff and the registered manager to discuss their work performance, future training and development plans and career aspirations. A staff member commented, "I have recently had an appraisal with the manager."

Staff members were able to describe their role and responsibilities. They told us when they began working at the home they had completed an induction programme which included a week at headquarters and they had the opportunity to shadow a more experienced member of staff when they came into the home. This was needed to ensure they had the basic knowledge needed to begin work. The registered manager told us the organisation was introducing the Skills for Care, Care Certificate as part of staff induction to increase

their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

Staff members confirmed they received some training to carry out their role. One staff member commented, "There are opportunities for training. I have done dementia care, dignity and end of life care training." Another staff member said, "I just finished fire training yesterday." Other staff comments included, "I have done wound care and first aid training. I'm doing fire training next week" and "Training is quite good, it is regular."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was working within the principles of the MCA. DoLS were applied for appropriately. 19 DoLS were in place which had been legally authorised and one application was being processed. Staff were also aware of some daily best interests decision making, where they may make an everyday decision on behalf of people who do not make their needs known.

The home was spacious, bright and airy. An enclosed garden was available with a sitting area that we observed was used by people and relatives. The communal areas and hallways of the home had decorations and pictures of interest and sitting areas were available around the home. There was appropriate signage around most of the building to help maintain people's orientation. Lavatories and bathrooms were signed for people to identify the room to help maintain their independence. However, we considered some improvements could be made to ensure people were kept orientated in other areas of the home. People's bedroom doors did not all provide signage to help them identify their bedroom. Menus although available in written and pictorial format were small and difficult to read, orientation boards were not available that provided accessible information advertising days of the week, staff on duty and other information to keep people informed. Calendars and clocks were also not available to remind people. We discussed this with the registered manager who told us it would be addressed.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives

People's special diets and any cultural or vegetarian preferences were respected. Food was well presented and looked appetising. A choice of main meal was available at each meal. People were offered regular drinks and snacks throughout the day in addition to the main meal. People and relatives were positive about the food saying there was enough to eat. One person told us, "I get plenty to drink." Another person said, "There is a choice of food." Other people's comments included, "I love the Sunday lunch, pork or

chicken but last week there were no Yorkshire puddings and "The food is good, I'd be the first to complain if it wasn't." A relative told us, "Food is excellent."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up-to-date and showed people with nursing needs were routinely assessed against the risk of poor nutrition using a recognised nutritional screening tool. A system called 'tear drop' was developed by the home that advertised to staff where people's fluid intake required monitoring. Food and fluid charts recorded people's nutritional and fluid intake. However, the fluid intake charts did not all show that amounts had been totalled and if the required amount of fluid had been taken. After the inspection, the provider could demonstrate that these had been reviewed by the nurse and where action was required for a person who had not had sufficient fluid intake through the day that this had been handed over to the nurse taking over to ensure appropriate actions were taken and recorded.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. People and relatives praised the effective care provided, in terms of their health or family members' health and well-being. One person commented, "I feel much stronger since I came here, I get physiotherapy three times a week." Another person said, "I am keeping my independence here, they [staff] encourage me to do things myself." One relative told us, "Since being here [Name] has achieved a lot in three weeks, their confidence is building. They [staff] have gone far deeper into [Name]'s problems and they see a GP regularly."

Good

Is the service caring?

Our findings

People and relatives we spoke with said staff were kind, caring and patient. One person told us, "I am in a safe environment with people who care." Another person commented, "Staff made me very comfy when I arrived. I think it's outstanding here." Other people's comments included, "The staff are very understanding", "I am better off now than I ever have been", "It is very friendly here", "Staff are always popping their heads in to see me, I am getting to know them quite well", "I am home here, nothing is a problem to staff", "We are very well-looked after", "Staff do their best" and "They [provider] seem to have the right calibre of staff." A relative told us, [Name] is well-cared for here." Another relative commented, "It is an excellent care home, it has a very good reputation. The care is excellent."

During the inspection there was a pleasant atmosphere in the home. Staff interacted well with people. People appeared calm and relaxed as they were supported by staff. Staff were warm, kind, caring and respectful. They modified their tone and volume as they engaged with people. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging.

We observed the lunch time meal in the dining rooms. People enjoyed a positive dining experience at the meal time, the atmosphere was calm in dining rooms, however, in one dining room there was little staff interaction with people. We discussed with the registered manager our observations where a staff member's interaction with other staff members had not been appropriate as they assisted a person to eat in the same dining room. They told us this would be addressed. Most people were served in the dining room and staff were available to provide support and encouragement or full assistance to people. We heard staff ask people for permission before supporting them, for example with assisting them to the dining table or offering them protective clothing at the meal. Food was well presented and hot and cold drinks were served. A choice of main meal was available at each meal. People sat at tables that were well set with tablecloths, flowers, napkins and condiments.

People's care records contained information about people's likes, dislikes and preferred routines. Examples in care records included, 'I hate to be alone', 'I dislike butter on my bread', 'I like to have my television or radio on in my bedroom' and 'Please use the lamp in my room and not the bright main light.' However, such information was limited in some people's care records to help ensure staff provided person-centred care when the person was unable to tell staff about their routines and how they wanted their care to be delivered. We discussed this with the registered manager who told us it would be addressed.

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support needs and they could approach staff at any time. One relative commented, "Any problems and they [staff] ring me or my brother straight away."

People were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Staff we spoke with had a good knowledge of the people

they supported. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff told us they also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Bedroom doors were closed when staff assisted people in their bedroom to protect their dignity. Records were held securely and policies were available for staff to make them aware of the need to handle information confidentially.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they might like to do. One person told us, "I can have a shower when I want I just have to ask." Another person commented, "I can have a long lie-in bed when I want." We heard staff ask people for permission before supporting them, for example with personal care or assisting them to stand up.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we had concerns that records were not all in place for people to receive person-centred care. At this inspection we found improvements had been made and the service was no longer in breach of this requirement. However, we considered further improvements were needed to record keeping to ensure that they all accurately reflected people's care and support needs.

Comprehensive information was now available in most people's care records that reflected their care and support requirements. Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation but they did not all reflect any changes that had taken place. Evaluations forms included some information about people's progress and well-being, but some evaluations only detailed, 'No change' and did not capture how the person's well-being had been during the month. We discussed this with the registered manager who told us it would be addressed with staff. Reviews of peoples' care and support needs took place with relevant people.

Most care plans were in place that provided guidance for staff about how the person's care needs were to be met. However, a care plan for moving and assisting and a care plan for visual impairment did not accurately reflect a person's current care and support needs. This was addressed immediately and we received information straight after the inspection to show it had been addressed. Care plans did not all detail what the person could do to be involved and to maintain some independence. For example, one care plan for personal hygiene stated, 'Requires two members of staff for all hygiene requirements." Although it contained some information, it did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For a person who displayed distressed behaviour a behaviour management care plan was not in place which documented what staff needed to do to recognise triggers or de-escalate the situation when a person became agitated or upset. We received examples of improvements that had been made to the identified care plans after the inspection.

Staff said communication was effective within the home. A handover session took place between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member told us "Communication is effective." Another staff member said, "We have a handover when we come on duty to find out how people are." A handover sheet was used that contained written prompts for staff as they passed over information about people's needs.

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. However, the records did not provide an accurate account of all the checks carried out by staff. We saw some staff recorded their interventions on the form to ensure all their interventions with the person were recorded but not all staff did this. We discussed the form

with the registered manager and advised all recording should be consistent to ensure daily interventions with people were captured. They sent us a revised form after the inspection to show that this had been addressed. These records were used to make sure staff had information that was accurate so people could be supported in line with their current needs.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs.

Two activities personnel were employed. One person had been recently appointed. On the day of inspection one activities person was on duty. An activities programme was available on each floor that advertised daily activities. A record of activities was maintained by the activity co-ordinator and people were offered the opportunity to be involved if they wished. People confirmed activities, seasonal entertainment, parties and organised trips took place. One person commented, "We go on outings every Thursday afternoon. We go to local pubs, garden centres and have a meal out." Another person said, "It is lovely to see the countryside again, the lambs, but the bus is limited to the amount of people it can take." A third person told us, "It's spot on here, there is something happening every day." Other comments included, "They had a big party for my hundredth birthday. They brought the Lord Mayor. It was a lovely day", "I enjoy the bingo", "I'm watching another film that is on in the lounge", "It's nice and peaceful here, someone to talk to if I want, or if I want to be left alone that's okay" and "We are going to the theatre in July to see Cats."

We did not observe activities taking place on the ground floor of the home on the day of inspection. The only observed engagement with staff and people was at mealtimes and when the drinks trolley came around or when people were assisted with personal care. During the day we saw several people sat sleeping in the lounges in front of a television. On the ground floor a jigsaw was available and a person was completing it. We did not observe staff spend time sitting with people and talking to them. They did not offer people a choice of activities in small groups or individually when the activities person was not available. Staff said they were busy and this was confirmed by some people. One person commented, "The staff have no time to talk they are too busy." Another person told us, "Staff don't seem to have much time, they are normally quite busy." We discussed this with the registered manager who told us it would be addressed.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. Several compliments and cards of appreciation were available from people and relatives thanking staff for the care provided.

Requires Improvement

Is the service well-led?

Our findings

Improvements had been made to service provision and action had been taken to achieve compliance with the regulations since the last inspection, although compliance had not been achieved in a timely way. The provider had not adhered to the timescale on the action plan they had submitted after the last inspection to show that action that would be taken to ensure people received safe and effective care.

At this inspection further improvements were required in the identified areas such as staff training, staff deployment, accessible information and orientation, care records and record keeping which were discussed at the inspection. We received information straight after the inspection to show action that was being taken with regard to records and staff training.

Although care records were audited we considered they needed to be audited more frequently to ensure the quality of recording, to ensure they evidenced the care provided by staff, that they were up-to-date and accurately reflected people's care and support requirements. Staff training also required more regular auditing to ensure staff were completing the required training and other training that was provided. Quality assurance processes also needed to ensure it checked staff deployment to review the time staff had time to interact with people.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The home had a registered manager who had become registered with the Care Quality Commission as manager for Wheatfield Court in July 2017. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. They showed action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included for the nurse call system, fire checks and for the safe maintenance of the premises. Monthly audits included checks on staff training, medicines management, mattress checks, dining experience, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility, health and safety and accidents and incidents. Other in-depth audits took place that included health and safety and infection control.

The registered manager told us about the 'resident of the day scheme' where a person's care records, their bedroom, likes and dislikes and other aspects of their care were checked.

The registered manager told us monthly visits were carried out by the regional manager or quality manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, medicines records, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. We noted the results from a visit in May 2018. The overall score was 89%. One area, 'the customer journey' achieved 100%, 'home standards' scored 91%, 'staff review' 82% and 'clinical review' 89%. Action plans were produced from monthly visits with timescales for action where deficits were identified

The atmosphere in the home was lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One person told us, "I think the manager is very good, there have been a lot of improvements." Another person commented, "The manager is always available." Several staff members said, "The manager is approachable."

Staff were positive about the management of the home and had respect for them. Staff commented they worked as a team and we observed they knew what they doing as they supported people. One staff member told us, "It's smashing working here." Another staff member commented, "It is different to working in the community but I enjoy it." A third staff member said, "There are opportunities for development and progression."

People and their relatives were kept involved and consulted about the running of the service. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, safeguarding, survey results, advocacy and forthcoming events. Meetings took place with them and minutes were available for people who were unable to attend. One relative commented, "[Name]'s daughter usually goes to the meetings." Meeting minutes showed items discussed related to the running of the home, activities and outings and proposed changes.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "Staff meetings happen two monthly." Another staff member told us, "Senior staff have a monthly meeting."

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and staff. Results were available from a survey in February 2018 which showed that comments were very positive, where suggestions had been made for improvements for example to menus these had been actioned and the results advertised showing what people said and the action taken. The cook also told us, "People were asked about food in the survey and they said there was too much fish pie. We have reviewed the menus to alter this. We are adjusting to seasonal menus."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)