Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Wingfield is a care home with nursing service, registered to provide personal and nursing care for up to 89 older people. The Wingfield is part of Barchester Healthcare Homes Limited; a large provider organisation. The service is housed in two separate buildings a short walk from each other on a site that is also shared with a GP surgery and pharmacy. The smaller building; The Lodge, has accommodation over three floors for up to 32 people. The second building; Memory Lane, has accommodation on two floors for up to 57 people, and specialises in providing care to people living with dementia. At the time of our inspection 23 people were living at The Lodge and 48 people at Memory Lane.

The inspection took place on the 1 and 2 November 2016. The first day of the inspection was unannounced.

The service did not have a registered manager in post. 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 deputy manager and two operations managers who were responsible for the day to day running of the service. One of the operations managers was in the process of applying to be the registered manager.

At the last comprehensive inspection in August 2015 we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because insufficient care staff were deployed which meant care was not consistently provided in a timely way, the service did not effectively assess and promote infection control, the service did not always follow the requirements of the Mental Capacity Act 2005 when people did not have capacity to consent to care and treatment. In addition, the service did not have effective quality and safety assurance information gathering systems in place.

At this inspection we found that the provider had taken action to address some of the issues highlighted in the action plan, however some issues remained and still needed improvement. The service was managing risks of infection effectively. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection.

Staffing levels had improved, however staff were more effectively deployed in the Lodge, than they were on Memory Lane. The majority of people living in Memory Lane stayed in their bedrooms and did not see staff other than when care tasks were completed, which meant people could be at risk of social isolation.

The requirements set out in the Mental Capacity Act 2005 (MCA) were not always followed when people lacked the capacity to give consent to living and receiving care at the home. People living with dementia were not always supported to make choices. At The Lodge staff said they had received training on this topic and understood the importance of encouraging and enabling people to make informed choices about their

daily lives. On Memory Lane permission was not always sought from people prior to tasks being undertaken.

People told us they enjoyed the food and there was a good choice of meals. The chef knew people's likes and dislikes as well as nutritional requirements. At The Lodge, people had access to food and drinks throughout our inspection. At Memory Lane people were not always supported to eat sufficient food and records did not accurately reflect what people had or had not eaten.

People's privacy and dignity was not always respected. On Memory Lane we observed staff consistently entering people's rooms without knocking or seeking permission to enter. There was a pleasant and friendly atmosphere throughout The Lodge.

Care plans were regularly reviewed, but the quality of information within the plans was variable. Although some were comprehensive and detailed, others were not and contained conflicting information.

Complaints and concerns were investigated, however not always responded to in a timely way. We found that for some complaints measures were not put in place to prevent incidents from reoccurring.

People who were able to tell us said they felt safe. Comments included "Yes I do like it here; I can take it or leave it. I've been here for years, Yes I feel safe here."

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this.

Systems were in place for the safe storage, administration and disposal of medicines. Records showed people received their medicines as prescribed and in their preferred manner. People had access to healthcare services to maintain good health.

Safe recruitment practices were followed before new staff were employed to work with people. People received individualised care and support from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff told us they had access to training appropriate to their role. New staff received a comprehensive induction prior to working independently with people.

People were supported to follow their interests and take part in social activities. There was a timetable of weekly activities, which included a book club, cooking, day trips and arts and crafts. Whilst group activities were on offer daily the activities coordinator told us they currently had two days a week where they offered people 1:1 social stimulation. We observed during our two days of inspection that there were many people on Memory lane who remained in their room. Those who remained in their rooms were only visited when staff were providing a care task. This put people at risk of social isolation.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

The provider had quality monitoring systems in place. Accidents and incidents were investigated and discussed with staff to minimise the risks or reoccurrence.

Staff we spoke with were positive about the support they received and felt they could approach management with their concerns at any time.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was sufficient staff, however the staff was not deployed effectively on Memory Lane, which meant people were left unattended for long periods.

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Systems were in place for the safe storage, administration and disposal of medicines.

Risks to people's safety had been assessed and plans were in place to minimise these risks.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistently meeting the requirements of the Mental Capacity Act 2005. People were not always supported to make decisions or were not always given choices.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected.

Interactions between staff and people were not consistently positive between the service, especially interactions with people living with dementia.

People and their relatives spoke positively about the care and support provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were regularly reviewed, but the quality of information within the plans was variable.

Daily personal care records were in place but did not contain details of the person's emotional well-being or the support which had been offered.

Complaints and concerns raised by people or their relatives were not investigated and responded to in a timely way.

People were supported to follow their interests and take part in social activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The leadership of the service had improved, but further work was needed to build on the changes that had been made and embed them in practice.

The service did not have a registered manager in post.

Management systems were used to regularly review the service and identify where to prioritise action.

Staff felt supported by the management team and could raise concerns and seek guidance.

The Wingfield

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.

We carried out this inspection over two days on the 1 and 2 November 2016. The first day of the inspection was unannounced. Two inspectors and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last comprehensive inspection in August 2015 we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with eight people who use the service and seven visiting relatives about their views on the quality of the care and support being provided.

During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included eight care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the deputy manager, operations manager, six care staff, two registered nurses, housekeeping staff, staff from the catering department, maintenance, activities coordinator and a health professional who worked alongside the service.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in August 2015 we identified that the service was not meeting Regulation 18 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because sufficient numbers of staff were not deployed fully to meet people's needs for person centred care. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found staffing levels had improved, however staff were more effectively deployed in the Lodge, than they were on Memory Lane. The service used its 'dependency indicated care equation' form (DICE) to work out nursing and care staffing levels. We asked the deputy manager whether the staffing levels generated by the DICE were sufficient. They said additional environmental factors, such as The Lodge having three floors, were factored in and they felt the staff ratio to people were sufficient. In The Lodge people told us staff responded to their needs quickly and they didn't have to wait long when they used their call bell. On Memory Lane we saw that for most people, they were unable to use their call bell. Call bell risk assessments were in place, stating where people were unable to use their call bells, they should be checked on at least hourly. We found this didn't always happen and the lay out of the building in Memory lane meant that people further down the corridor were left unattended in their rooms for longer than an hour.

The provider's action plan stated staff would continue to oversee the lounges when people were present in order to ensure no person was left unattended for periods of time. We observed three people in the lounge on the first floor of Memory Lane on the second day of our inspection. We saw that people were sat in the same position from 10.15 until 12.15 with no staff checking in on them. We observed another person was sat in their chair in their bedroom with the only interaction from staff when they were given a drink or their meal. Some people on Memory Lane were calling out in the afternoon with no staff to be found. Staff told us they were meeting people's physical needs, however did not feel they had time to spend with people. They explained that when they had finished people's personal care in the morning, it was time to start serving lunch. We also observed that for some people breakfast was not served until 10.30 in the morning. Speaking with relatives they said "I come in every afternoon to sit with my wife. This place lacks a personal touch" and "I have a feeling that they are short-staffed. And it's worse at weekends, not so many staff around."

People who were unable to use their call bells were heard calling out but there were no staff present to respond. On the second day of our inspection we heard one person calling out. We could not find any staff to support so knocked on their door and asked if we could enter. The person said they would like a drink. It took about ten minutes for us to locate a staff member who then supported the person to have a drink.

This was in breach of Regulation 18 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

At the last comprehensive inspection in August 2015 we identified that the service was not meeting Regulation 12 (1) (2) (h) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because some stairwells and sluice areas in home were not cleaned to a sufficient standard, and other

preventative steps had not been taken in relation to infection control such as using separate hoist slings for each individual, and disposing of incontinence waste products appropriately. This meant the home did not always manage the risk of infection. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found improvements had been made and the service was managing risks of infection effectively. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. Staff could explain the procedures they would follow to minimise the spread of infection and how they would handle soiled laundry. A head of housekeeping had been employed to oversee the cleaning schedules and infection control. We observed staff following the infection control procedures in relation to separating soiled laundry, using cleaning equipment that was specific to the area being cleaned and following good food hygiene procedures. A nurse in charge told us sluices were checked twice daily to ensure no contaminated items were left for any period of time. This action was completed by the nurse on duty on each unit and then documented on the nurse communication sheet. We also found the service had purchased additional slings and people now had their personal sling where required. The management team completed regular infection control audits to assess how the procedures were being put into practice.

People who were able to tell us said they felt safe. Comments included "Yes I do like it here; I can take it or leave it. I've been here for years, Yes I feel safe here.", "Safe, yes I feel safe. Always locked up at nights.", "Yes I feel safe; you're not living on your own. And yes I do like it here, the staff are good during the day, but not so at night." And "Yes I feel safe here; the staff here really looks after you. And yes I like it here I have made friends here."

People were kept safe by staff who recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this. Comments from staff included "We have to make sure people are safe. If I saw poor practice then I would hold a supervision meeting with staff and discuss this. I would also report this to the manager if the practice did not change", "Part of my role is mentoring staff so we talk about what is good practice during our supervisions. For example how to use equipment correctly and how to transfer people" and "I strive for perfection and will tell people if they are not doing it right. I would report it to the nurse who would do something".

Staff said they would report abuse if they were concerned and were confident the registered manager would act on their concerns. Staff were aware of the option to take their concerns to agencies outside of the service if they felt actions to deal with their concerns were not being taken.

Risks to people's safety had been assessed and plans were in place to minimise these risks. This included risks in relation to falls, malnutrition and developing pressure ulceration. There was clear information in people's care plans which provided staff with guidance on how to reduce these risks. For example, for one person who was a risk of falling their plan contained information for staff to ensure they kept the corridor where they frequently walked 'clutter' free. A sensor mat had been put in place to alert night staff that this person had got up so they could go and offer assistance if required.

Occasionally people became upset, anxious or emotional. We found strategies were recorded in people's care records to guide staff on what to do in case a person showed behaviour which could be challenging for others. However these strategies were not always clear, for example in one person's care plan it stated they could become anxious at night and shout out. It said "Staff need to establish interpersonal relationship with the person." This was not clear guidance for staff on what to do to reassure the person.

People's medicines were managed and administered safely. The administration of medicines was restricted to the registered nurses who had received training in the safe administering of medicines. There were records to demonstrate that checks had been undertaken to ensure they were competent to administer people's medicines.

We looked at the current medicines administration records in the home. The pharmacy provided printed Medicine Administration Records (MAR) for the nurses to complete when they gave people their medicines. Most medicine Administration Records (MAR) were found to be up to date with all signatures in place. Records at The Lodge had some gaps in recording. We spoke with the nurse who confirmed that it was a recording issue and that these would be followed up. Nursing staff confirmed that MARs would only be signed once they had witnessed the person taking their medicines.

Medicines were stored securely. Medicines were stored in accordance with their storage requirements and storage temperatures were checked and recorded daily in line with this. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies were recorded. Processes were in place to ensure medicines that were no longer required were disposed of safely.

Staff supported people to take their medicines correctly. On the day of the inspection no people were being given their medicines covertly (without their knowledge, mixed with food and/or drink). We observed parts of the medicines rounds in both The Lodge and Memory Lane. Medicines were administered in a safe and respectful way. Nursing staff stayed with the person to ensure they had swallowed their medicines and drinks safely. Where people were not ready to take their medicine the nurse respected this and returned when they were ready. For example, one person said they were not ready to take their medicines and the nurse explained they would come back later. Where people refused their medicines this was respected. It was recorded on their MAR and where required medical advice was sought.

People were protected from the risk of being cared for by unsuitable staff. We saw safe recruitment and selection processes were in place. Staff personnel records showed appropriate checks were undertaken before they commenced work. These records included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of the person's identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. The deputy manager explained new staff were subject to a formal interview prior to being employed by the service. They were also shown around the home as part of an informal interview where their interactions with people would be observed.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection in August 2015 we identified that the service was not meeting Regulation 11(1) (2) (3) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because the requirements set out in the Mental Capacity Act 2005 (MCA) were not always followed when people lacked the capacity to give consent to living and receiving care at the home. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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 be 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At The Lodge staff said they had received training on this topic and understood the importance of encouraging and enabling people to make informed choices about their daily lives. They explained people were always offered the choice of what they wanted to eat and drink, what clothes to wear and how they wanted to spend their day. One staff member told us "Everyone has capacity to make some decisions. People just make their decisions in different ways".

On Memory Lane permission was not always sought from people prior to tasks being undertaken. For example, we observed one staff member cleaning one person's hands and face. They did not ask the person if it was alright to do this or explain what it was they were doing. We saw another member of staff move someone who was in a wheelchair without asking their permission. We also found that for particular decisions such as the use of monitoring equipment and the use of bed rails, best interest decisions were made, however mental capacity assessments to support the decision, was not in place. Some best interest decisions were made by relatives who did not have a lasting power of attorney to do so. A power of attorney has legal authority to act on a person's behalf in some circumstances and can relate to decisions about finance or the person's health and welfare. Where best interest decisions were made, it was not always recorded how the decision should be reached, for example we saw evidence of a relative declining an appointment for an aortic aneurism screening, which is a way of detecting a dangerous swelling of the aorta. It usually causes no symptoms; however if it bursts, it's extremely dangerous and usually fatal. The reasons for reaching the decision, who was consulted to help work out the best interests and what factors were taken into account were not recorded.

This was in breach of Regulation 11(1) (2) (3) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

At The Lodge, people had access to food and drinks throughout our inspection. We observed people at lunchtime and found there were drinks on the tables and people were offered wine with their lunch. People had a choice of what they wanted to eat, for example staff came out with plated meals to show people what they could have. On the day of our inspection people had a choice between sweet and sour chicken or plaice fillets. There was a happy atmosphere with lots of interaction from staff. People told us they enjoyed the food and there was a good choice of meals. Comments included "I like old fashioned cooking but at least I get a choice. We can always get food between meals like now, mince pies and a cup of tea." And "The food is good I like everything they cook, there's a menu on the table where we get a choice." Speaking with relatives they said "Food is very nice; I have had dinner here" and "My mother did have an eating problem, but not now. And she has a good choice of menu, it's fabulous."

At Memory Lane people were not always supported to eat sufficient food and records did not accurately reflect what people had or had not eaten. For example, we saw that at 13.00 on the second day of our inspection one person had their lunch put in front of them. However, this person was asleep and at 13.40 the person's food was taken away uneaten and no alternatives were offered. When we looked at their daily evaluation records it noted the person had 'eaten and drank well' and there was no record of the person not eating lunch. We observed two more people not eating their lunch and records again stated they had 'eaten and drank well'. This meant staff might not be aware the person had not eaten for several hours and be able to offer additional snacks.

In another person's care plan it noted they were at high risk of malnutrition and their food intake was to be monitored. There were no records in place. When we spoke to staff about this they said they had just returned from holiday and prior to this the person had monitoring charts in place. We asked if the removal of the charts had been discussed in handover and their response was that it had not. They were therefore unaware if the person should or should not have monitoring charts in place. We observed this person did not eat the majority of their lunch. In their care plan it stated this person was to be encouraged to 'finish their meal'. An agency nurse entered the person's room asking if they had finished their meal. They did not offer any encouragement for the person to finish their meal as per the guidance in their care plan. They did not ask if the person wanted anything else to eat. Daily evaluation records noted the person had 'eaten and drank well' and made no reference to the person not eating their lunch.

We observed there were no snacks or drinks left out for people in between meal times on Memory Lane. Most people stayed in their bedrooms and had drinks by their beds, however we observed that those people were either unable to reach the drink or due to their dementia, was unable to remember that the drink was there. Hostesses went around with a trolley to offer a hot drink; however that was during a specific time in the morning and afternoon. We observed people were not given a choice of what they wanted to drink, for example people on Memory Lane were not asked if they wanted tea or coffee. Some people were able to go to the dining room for their lunch. Unlike The Lodge, people were not shown what choice of meals was available and people only had a choice of water or squash. The chef told us there was always snacks, cakes, fruit, smoothies and yogurts available for people in the kitchen, which staff had access to. However, we did not observe staff offering people snacks outside of meal times.

This was in breach of Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We found that Memory Lane, who specialised in providing care to people living with dementia, was not dementia friendly. People living with dementia can experience difficulties with their sight and perception and the use of colour and contrast could help a person to identify objects or find their way around a building. The walls were all painted in a natural colour and there were no signs for example for the

bathroom or dining room to direct people where to go. The flooring also caused confusion for some people and a relative told us of a person who was reluctant to go into their own bathroom as the floor looked like water.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals, such as a chiropodist, optician, district nurse, or tissue viability nurse. Care plans confirmed people had access to health care professionals. Visits from health care professionals were recorded and any outcomes of these visits.

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. New members were supported to complete an induction programme which incorporated the Care Certificate at the start of their employment. The care certificate covers an identified set of standards which health and social care workers are expected to adhere to. They were able to shadow more experienced members of staff before working independently. A senior care worker explained that part of their role was to mentor new care staff to ensure they were "Working correctly". There was a training matrix in place which recorded the training staff had completed and staff said they were supported to refresh their training as required. Training undertaken by staff included safeguarding of vulnerable adults, Mental Capacity Act, fire safety, infection control and moving & handling. The training matrix confirmed that the majority of staff had completed this training.

Staff told us they received regular supervisions and annual appraisals which supported them in their role. There was a matrix in place which detailed when staff had received their supervision and appraisal. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always respected. On Memory Lane we observed staff consistently entering people's rooms without knocking or seeking permission to enter. We saw that one person was walking around and going into other people's rooms without staff intervening. We asked a staff member if people did not get upset, which they replied to "No, they have dementia. They're not even aware the other person is there". During one occasion the person had gone into another person's room and was trying to remove the cushion on the bed rail. We had to go and find a staff member to direct the person out of the room, who said "[Person] could have really injured the person in bed".

We observed staff consistently moving people who were in wheelchairs without first telling them they were going to do this and where the person was going. People were brought into the lounge and were not asked where they would like to sit. The radio was put on, again without asking people if they wanted it on and what music they would like to listen to.

We observed one staff member encouraging a person to leave the lounge to come to the dining area for their tea time meal. However, the staff member did not give the person time to process the request by repeatedly asking the person if they wished to come for "Tea", "High tea" and "Dinner". This may have been confusing for the person who was living with dementia as the staff member was not making the request in a consistent manner.

We observed another member of staff approach a person during the lunchtime on our first day and take the person's knife and fork away without seeking permission or telling them what they were doing. They then proceeded to cut up the person's food and started to assist them to eat. They did not ask the person if they required assistance. They then took the food away and brought the person dessert, again without asking them what they would like. Another example was where a member of staff approached a person at breakfast time. They picked up a sandwich and put it in the person's mouth and said "You can do this for yourself" before walking away.

Some staff told us they did not have time to spend with people on Memory Lane. We observed that interactions between staff and people were limited to meal and drink times and sometimes rushed. We saw a member of staff supporting a person to eat at breakfast. The person kept falling asleep with the staff member continuously putting a spoonful of food in their mouth without allowing time between mouthfuls. The member of staff was standing over the person while supporting them.

This was a breach of Regulation 10 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We observed some positive interactions with staff on Memory Lane asking a person "Where would you like to go [person]. The lounge or your room?" Another person was getting distressed during a fire drill and we saw staff talking to the person in a reassuring way.

There was a pleasant and friendly atmosphere throughout The Lodge. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included items such as ornaments, photographs and their own furniture. People were treated with kindness and compassion. We observed staff taking the time to explain to people what was happening. For example, we observed one person being transferred from their wheelchair into an arm chair. Staff explained what was happening, encouraging the person to be as independent as they were able and offering reassurance.

Speaking with staff at The Lodge, they demonstrated they cared a great deal for the people they supported. Staff told us they felt that people received high standard of care and support. Comments included "We want to improve as a team and give good care. We have time to spend with people getting to know them" and "We know people well. We know their likes and dislikes and support people to be independent and make choices.

We saw that when people at The Lodge were approached by care staff they responded to them with smiles, by sharing jokes or by touching their arm which showed people were comfortable and relaxed with staff. We observed people walking freely around the home and interacting with staff. Staff took their time with people and did not rush or hurry them. Staff showed concern for people's wellbeing in a caring and meaningful way. People looked comfortable in the presence of staff and did not hesitate to seek assistance and support when required.

People at The Lodge were treated with dignity and their privacy was respected. People were addressed by staff using their preferred names and staff knocked on people's doors before entering their rooms. People commented "Yes the staff are caring towards me, and they always knock on my door, they treat me with respect." And "Yes, they all mean well. They draw the curtains and they always knock on the door before they come into my room."

When people received personal care, staff ensured this was done behind closed doors. One member of staff told us "I always ensure that the door is shut and the curtains are closed when helping someone with their personal care. I ask permission before I do anything and explain what I'm doing". Another member of staff said "Its people's choice when they want to get up and I encourage people to do as much for themselves as I can".

Requires Improvement

Is the service responsive?

Our findings

Care plans were regularly reviewed, but the quality of information within the plans was variable. For some people we saw their care plans stated they needed support with personal care, however it did not state how the person would like their personal care done. Some care plans were comprehensive and detailed, others were not and contained conflicting information. For example, in one person's nutritional plan it noted the amount of feed required for their RIG feed and the amount of water required and frequency the RIG needed to be flushed. A RIG (Radiologically Inserted Gastrostomy) is a technique whereby a narrow plastic tube is inserted through the skin, directly into the person's stomach. Once in place the tube can be used to give the person a liquid feed directly into their stomach to provide nutrition. However, in the person's RIG feed guidance it did not mention the need to regularly flush the RIG to prevent a blockage. This meant nursing staff who were not familiar with this routine might not be aware of how often they were required to flush the RIG. Evidence we saw suggested that the flushes were completed correctly.

Another person's care plan noted they had 'No mental capacity' and all decisions were made in their best interest in the mental health section. However in the other sections of their plan it stated the person could make choices regarding certain aspects of their care. For example, in the spiritual and cultural section it was recorded that 'X may agree to join in certain activities but they can say no if they are not interested'. In the communication section it stated the person was able to communicate their needs. This information contradicted each other and could be confusing for staff who were not familiar with this person.

Daily personal care records were in place but did not contain details of the person's emotional well-being or the support which had been offered. The records were task focused and recorded when personal care had taken place but not how the person had been whilst these tasks were being carried out. Where follow up actions were required these had not always been documented. For example, in one person's record it noted that on the 31 October they had been sneezing and coughing and care staff were to monitor this. There was no record of any further observations or actions taken after this date. One person's records noted they had refused to change their clothes but there was no information about how staff had tried to encourage this and what if any further actions had been taken. For another person it noted 'X has been very happy today' but contained no detail as to what the person had been doing which made them happy. Some records of food and fluid consumption were also inaccurate. It had been recorded in daily records that people had eaten and drank well when in fact they had not eaten any lunch.

This was in breach of Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

There was a procedure in place to manage complaints and concerns. At our last comprehensive inspection in August 2015 not all complaints and concerns had been recorded. During this inspection we saw that complaints and concerns were recorded, however found this was not always investigated and responded to in a timely way, contrary to the provider's complaints policy and procedures. We looked at complaints recorded and found a complaint in August 2016 from a relative, complaining about a person going into their family member's room. When they tried to allocate a staff member, no one could be found. During this

inspection, we observed that a person was still walking into other people's rooms without staff intervening. Some relatives we spoke with said they had also complained about the laundry as a lot of items got damaged or missing. One relative told us they were doing their family members laundry at home due to previous damage caused. We also saw evidence recorded during a resident and relatives' meeting in August 2016, where relatives brought up more concerns about the laundry. On the first day of our inspection, we met a relative in the reception area, who told us the laundry issue had not been resolved. The management team told us they would always replace items which were damaged in the laundry; however we could not see evidence of this issue being addressed to prevent further incidents occurring.

People were supported to follow their interests and take part in social activities. There were four activities coordinators in post who were responsible for organising activities for people throughout the week. There was a timetable of weekly activities, which included a book club, cooking, day trips and arts and crafts. The coordinators also organised outside entertainers who attended periodically throughout the year. One coordinator told us they regularly spoke with people about what activities they wished to take part in. People had a copy of the timetable in their rooms and were able to choose the activities they wished to join in with. People's comments included "This weekend was really good, went downstairs to a Halloween party. I like anything, I like bingo, and they give you chocolates", "There's not that many activities, I like the walks they go on and daytrips out, I've been taken out shopping." "Yes, I help cooking, like cakes. It gives me independence and we do lots of quizzes. I don't go on day trips. I'd like to go to the garden centre but they don't give you a chance to look at it." and "I Like to sing and yes they take you out." Relatives said "Yes my mother does all of the activities like flower arranging, arts and crafts, and goes along to the tea dance which she likes to watch." and "She [person] likes bingo and music and there's a guy who comes in, he's brilliant."

Whilst group activities were on offer daily the activities coordinator told us they currently had two days a week where they offered people one to one social stimulation. We observed during our two days of inspection that there were many people on Memory Lane who remained in their room. Those who remained in their rooms were only visited when staff were providing a care task. This put people at risk of social isolation.

In The Lodge staff we spoke with told us they had time to sit and chat or undertake activities with people. Most people living in The Lodge chose to sit in the communal lounge and only a few people remained in their rooms.

The activities coordinators kept records of activities people attended and produced a monthly evaluation and progress report. However, these records only contained information on the activities people had attended and not if the person had enjoyed the activity or to what degree they had taken part. This meant it was difficult to ascertain people's true involvement in the activity and if it was meeting their needs. One person was being nursed in bed and their activity evaluation recorded they received one to one time when they were awake and able to take part. It did not clarify how often this was and how much social interaction took place. This meant you would not know if the person had been visited once that month or more putting them at risk of social isolation.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection in August 2015 we identified that the service was not meeting Regulation 17 (1) (2) (a) (f) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because there were areas which were either not audited, or not in a fully effective way. Or, an audit had highlighted an issue which needed to be improved, but the improvement had not taken place. At our last inspection not all complaints, concerns and safeguarding matters had been recorded.

During this inspection we found internal audits, for example falls, maintenance and infection control audits, had been completed. For example the maintenance audit identified areas of improvement and as an outcome the reception area had been redecorated. There were also further plans of refurbishment to make the service fit for purpose. The provider had support groups visiting the service once a month, for example in hospitality, business management or dementia care. These groups went around the service checking for shortfalls and improvements.

The service had not had a registered manager in post, since the last registered manager left in October 2015. However, a manager from another service had been in post to support the day to day running of the service, but also left the service in July 2016. One of the current operations manager has applied to CQC to become the registered manager, while the process of recruiting a suitable manager continued. Staff told us the changes in management had been challenging and staff moral had been low. One staff member said "It used to be very stressful coming into work". However, there was now a deputy manager in post who was supported by two operations managers. Staff told us they had seen a change since the deputy manager and operations managers had been in post and it appeared that the service was getting back to what it used to be. People we spoke with said "All the managers left about the same time, and now the new ones just getting it together." and "Well we thought it was going downhill with the management change, but it got better. I haven't seen the new boss but I get on with [unit leader], and the staff are superb."

The management team told us their vision was to stabilise the service and recruit more staff and had therefore put an embargo on admissions until that had been achieved. There had been many staff changes the past year and management recognised the challenge of recruiting and retaining suitable staff. The deputy manager told us they were concentrating on improving the clinical governance of the service, while the operations manager was focussing on care profiling and risk assessments.

Staff we spoke with were positive about the support they received and felt they could approach management with their concerns at any time. Comments included "I get regular supervisions and can also chat with management in-between these meetings. I get enough support" and "I can talk about my own personal development. I have just finished my appraisal. The support here is good". Some staff told us they didn't always feel supported by the provider. They felt some Barchester principles were not always practical, for example written menus on the tables for people living on Memory Lane as pictorial menus would be more beneficial. Another example was where people had carpet in their rooms, but could benefit from different flooring due to continence difficulties. Staff told us the provider didn't always listen to their suggestions.

The Wingfield worked in partnership with families, the local authority, the library service, GP surgeries, hospitals, a local hospice service and other professionals. Best practice information also came directly from the provider organisation; Barchester Healthcare Homes Limited. For example, the provider issued weekly bulletins containing information and guidance to the management team which was then shared with staff. Many staff members had daily contact with the deputy manager during morning meetings at which information was shared and suggestions could be made. This included nurses, catering staff, housekeeping and maintenance.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Residents and relatives meetings were held and quality assurance surveys were sent out to people and their relatives once a year. Relatives told us they were not clear about who the managers were at present, but did know where the office was if they needed to discuss any concerns.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were regularly reviewed, but the quality of information within the plans was variable. For some people we saw their care plans stated they needed support with personal care, however it did not state how the person would like their personal care done. Some care plans were comprehensive and detailed, others were not and contained conflicting information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected. On Memory Lane we observed staff consistently entering people's rooms without knocking or seeking permission to enter.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements set out in the Mental Capacity Act 2005 (MCA) were not always followed when people lacked the capacity to give consent to living and receiving care at the home. People living with dementia were not always supported to make choices.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported to eat sufficient food and records did not accurately reflect what people had or had not eaten. This meant people were not always receiving care in a safe way to prevent risks to avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There has not been consistent leadership and consequently remaining in breach since the last comprehensive inspection in October 2015. We saw that complaints and concerns were recorded, however found this was not always investigated and responded to in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed fully to meet people's needs for person centred care.