Extraservice Limited

Fieldgate Nursing Home

Inspection report

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12 December 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

What life is like for people using this service:
• People did not receive a service that provided them with safe, effective, compassionate and high-quality care.
•The management of risk and medicines was ineffective and placed people at risk of harm.
•The environments had not been considered for people living with dementia and infection control risks had not been mitigated.
• People who remained in their rooms at all times were at risk of social isolation.
• People's human rights were not always upheld as the principles of the Mental Capacity Act 2005 were not adhered to. People were not empowered to make choices and have control over their care and people were not provided with support that was personalised to them.
• At our last inspection in August 2016, the provider was found to be in breach of Regulation 18 registration Regulations 2009 (failure to notify). At this inspection, we found improvements had been made and all notifiable events were being reported to the Care Quality Commission (CQC).
• We found a range of institutional practice taking place at Fieldgate nursing Home. People did not consistently receive person centred care that was based on based practice guidelines.
• The service was not well led and there was a lack of quality assurance processes in place. However, people told us staff were kind and treated them with respect.

Rating at last inspection: Good, last report published 19 August 2016.

About the service: Fieldgate Nursing Home is a residential and nursing home that was providing personal and nursing care to 32 people at the time of the inspection.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

At this inspection the service has been rated 'Inadequate'. Therefore, the service is now in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Fieldgate Nursing Home

Detailed findings

Background to this inspection

The 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 checked 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.'

Inspection team: One inspector, a Specialist Nurse Advisor (SPA) and an expert by experience (ExE) 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 care service.

Service and service type: Fieldgate Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection, they were providing a service to 32 people at Fieldgate Nursing Home. They are registered to provide accommodation and nursing or personal care for up to 39 people.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection site visit activity started on 11 December 2018 and ended on 12 December 2018.

What we did:
We reviewed information we had received about the service since the last inspection in August 2016. This included details about incidents the provider must notify us about, such as abuse. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection we reviewed a range of records. This inspection included speaking with 12 people, four relatives, five members of staff, the manager and the deputy manager. We reviewed records related to the care of five people and the medicine records for three people. We reviewed staff recruitment, supervision and appraisal records for four staff and the registered manager. We looked at records relating to the management of the service, policies and procedures, maintenance and quality assurance documentation. We asked for further information following the inspection including the training matrix, support plan and risk assessment relating to two people and the complaints log and these were received.

Inadequate

Is the service safe?

Our findings

People were not safe and not protected from avoidable harm.

Using medicines safely
• Medicines were not managed safely.
• Guidance produced by the Nursing and Midwifery Council (NMC) advises that registered nurses competency to administer medicines must be regularly reviewed and assessed. The competency of nursing staff employed at Fieldgate Nursing Home were only assessed following a medicine error and not on a regular basis in line with the guidance produced by the NMC. A few care staff had received training to assist with the administration of medicines. For example, care staff could support a person to take their medicines but only if a trained nurse had dispensed the medicine. Whilst care staff had received training, their competency assessment only consisted of three multiple choice questions. A member of the management team told us that a practical competency assessment also took place. However, there was no documentation to support that this occurred. From the information provided, there was insufficient evidence to indicate staff competency in this task.
• Safe practice was not followed to ensure peoples medicines were administered safely. Medicines for each person were stored in clear boxes within the medicine trolley, labelled with their name. We observed the nurse checked the name on the boxes before dispensing medication but they did not check expiry dates of medicines or check that the correct blister pack had been put back into the correct box. This meant there was a risk that people could be administered out of date medicine or medicine that was prescribed for someone else.
• Guidance on how people preferred to take their medicines was not readily available. For example, whether any special requirements were needed, such as thickened fluids or if the individual preferred to take the medicine with juice or from a spoon. This meant that people may not receive their medicines in their chosen way or the safest way.
• Safe practice was not followed to ensure people's medicines were safely stored. Not all creams were labelled with people's name or stored safely, this included where people shared a bedroom. This meant there was a risk that people could access creams not meant for them and a risk that people could ingest the creams. Opening dates were not recorded. This meant that people were at risk of being administered the wrong creams or creams that were no longer in date, once the expiration date has passed there is no guarantee that the medicine will be safe and effective. We observed creams that were stored in a bathroom cabinet which should have been locked, however the lock was broken. We discussed this with a member of the management team who made arrangements for this to be repaired.
• A NHS Patient Safety Alert published in 2015 identified a risk of asphyxiation by accidental ingestion of fluid/food thickening powder. During the inspection, we identified fluid thickening powder left in accessible reach of people. We brought these concerns to the attention of the registered manager who told us she didn't think the thickener had to be stored out of sight, just out of reach and because most people couldn't walk she felt it was ok for it to be left on a table in the lounge. This meant that people were at risk of significant harm or death from asphyxiation by accidental ingestion of fluid/food thickening powder.
• Medicines keys and cupboards were located in the nurse's rooms which had a keypad entry system for security. However, these were open on many occasions throughout the inspection and could easily be

accessed by people and visitors. The registered manager told us the doors should not be left open and that this would be raised with the registered nurses.
• The provider had a medicines policy in place. This stated that twice monthly medicines audits should be completed. However, the registered manager told us that medicines were instead audited monthly. Whilst the medicine policy was not being adhered to, the monthly medicine audit only consisted of a medicine count to check correct amounts which were correct. There were no other types of audits completed and consequently the registered manager lacked oversight of several shortfalls with the safe management of medicines. Alongside this, medicines were only counted once a month. This meant that discrepancies could go undetected for some time and could make it difficult to identify when error occurred.
• The National Institute for Health and Care Excellence (NICE) Guidelines state that 'everyone who lives in a care home should have a medication review at least once a year'. We found this guideline was not followed. The provider was unable to demonstrate who should be reviewing medicines or how often. A member of the management team told us they think the GP reviewed the medicines but stated this may or may not occur, they were unsure. One person told us, "I've been on the same tablets for three years and haven't seen the doctor about my medicines."
• We viewed the procedure for the administration of homely remedies (over the counter medicines) which listed medicines covered by this procedure. There was insufficient guidance regarding the maximum and frequency of doses for these medicines that people could have.
• The failure to ensure risks were assessed and effective plans implemented to mitigate these and a failure to ensure safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Risks to people had not always been assessed, monitored or mitigated effectively. For example, peoples' nutritional needs and malnutrition risk was not being assessed effectively. We saw in one person's care plan a MUST (Malnutrition universal screening tool) score of one which resulted in a recommendation to observe and monitor this person. There was no monitoring in place, for example, food and fluid charts in place. The daily care records had a section for completing food and fluid intake under the heading 'Feeding'. This record had not always been always completed and gave little reference to each meal / snack taken throughout the day. Another person's moving and handling risk assessment identified the use of a universal full sling. However, this was not completed fully. This meant that staff had no information relating to this person, for example if they required the use of a wheelchair.
• Not all areas of the environment were safe. For example, medical gloves were accessible to people. This could pose a risk to people with dementia. We identified areas in the home that were not secure and presented risks to people. Doors identified as 'keep locked' were not always locked and this meant that people could gain access to cleaning chemicals. There had not been a health and safety audit or any recorded checks to the environment carried out.
• One person had an oxygen cylinder in their bedroom. There was no sign on the door indicating that oxygen was in use. The Health and Safety Executive (HSE) states 'Employers are legally required to assess the risks in the workplace, and take all reasonably practicable precautions to ensure the safety of workers and members of the public. Include a careful examination of the risks from using oxygen in your risk assessment. A member of the management told us that there was a small box located by the main front door which contained details of people's, next of kin contact details and a building floor plan, for use by fire brigade. The management team were unable to demonstrate that the local fire brigade had been informed and if the local fire brigade knew the location of the oxygen therapy/cylinders There was no information accessible to inform people that oxygen was present in the service.
• People had individual care plans and risk assessments in place. Each care plan contained an index to aid location of documents. Care plans and assessments in general did not provide detailed information for individual people, consequently some care plans lacked detail in many aspects of how to support nurses

and carer's in providing best, evidence based care for people. For example, two people's care plans titled 'Mobility and Dexterity' stated 'If a hoist is used:' and listed things to consider if a hoist was used however, failed to state if the service user actually required the assistance of a hoist and if so, how to use it, what sling to use and what loop to use. Service user's preferences and wishes regarding hoisting had also not been captured.
• Nationally recognised tools to aid risk management were not utilised by the provider and we found other people had risks associated with health conditions but these had not always been assessed appropriately. For example, we observed a carer assisting a person with their meal. The person coughed after taking a large spoonful of pureed food then went quiet. The carer told us, "They often do this, they stop breathing, they go blue for a minute then takes a breath again when they are ready." The care plan and risk assessment contained insufficient detail for staff to support this person safely. For example; the care plan stated that the person coughs and changes colour, however it contained no detail about what the colour changes were and what this meant for the person. We asked the registered manager to review and update the care plan and risk management plan which they did, however it had to be reviewed three times in total before it contained sufficient information to ensure this person could be supported safely. We alerted the local authority of our findings.
• The lack of detailed comprehensive risk assessments placed people at risk of harm.
• The failure to ensure risks relating to the safety and welfare of people were assessed, managed and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• The failure to have effective systems and processes in place to monitor and mitigate risks to people and maintain an accurate, complete record in respect of each service user was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels
• Some recruitment practises were carried out to protect people from the employment of unsuitable staff, however interview records were not available. We spoke to the management team who told us that they did not record the interview because they liked it to be an informal chat. This meant that the provider could not evidence that appropriate questions were asked at interview. A member of the management team told us they would record the reasons if someone was unsuccessful at interview however, they could not provide and records to evidence that anyone had ever been unsuccessful. This meant we could not be assured of a thorough and robust recruitment process.
• Staffing levels were calculated using an on-line dependency tool. People told us they thought there were enough staff. One staff member commented, "I think there are enough staff." However, we observed that staff were constantly busy, supporting a lot of people in their bedrooms with personal care and feeding at meal times, staff did not have enough time to spend quality time with people. This meant that people were at risk of isolation.

Preventing and controlling infection
• Bed bumpers were noted to be clean but there was signs of significant wear and tear on some that we observed, rendering them susceptible to harbouring bacteria. A member of the management team told us, "We are looking at replacing them, we have replaced mattresses." We discussed the infection control risk and a member of the management team told us that it was next on their list." There was no documentation in place to demonstrate that this had been picked up. Following the inspection, we have been informed from the registered manager that these have now been replaced.
• Some of the chairs in the lounge were visibly dirty and had large holes in fabric exterior or were excessively worn. When asked what one thing staff would improve at Fieldgate Nursing Home, they told us the seating which was old and required replacing. One staff member said, "Spend a bit more money on chairs, furniture, I would like us to buy new ones, a few more tables, a nicer visual appearance." And another staff member

said, "Furniture, it is not all that great, it is too dated. They deserve to be comfortable, they have been here forever." The registered manager told us that it is up to the proprietor when they updated the furniture.
• We saw six pressure relieving cushions that were in very poor condition. The exterior covers were torn or completely worn. One of these cushions was labelled for use by a person who is known to be MRSA positive. The registered manager told us they had some on order and that the old ones should have been removed. We were concerned that these cushions were in such a poor state of repair, that they had been in place, and an infection control risk, for a significant period of time. Following the inspection, we have been informed from the registered manager that these have now been replaced.
• Slings were shared between people for hoisting. There was no documentation available relating to laundering of these slings. This was a potential infection control hazard and risk of cross infection. Care plans and risk assessments did not detail which sling should be used for people. Ceiling extractor fans were dirty and clogged with dust in the toilet. This can result in a dusty or smelly bathroom and can lead to a build-up of mould.
• The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Risk assessments and care plans were not always reviewed following incidents. For example, we were told that a person often coughs while eating and goes blue on a regular basis, support plans and risk assessments contained no detail about their colour change and limited information about the process to follow if they choked on food. We ask the registered manager to update these records which was completed three times before they contained satisfactory detail.
• The provider had a system to record accidents and incidents. However, an analysis of accidents and incidents was not documented, therefore there was no evidence that themes and patterns had been identified and preventative measures put in place.

Safeguarding systems and processes
• People told us that they felt safe living at Fieldgate Nursing Home. However, one relative told us that when his father was in his bedroom the call bell was not always in reach. He said, "If he had a problem, he wouldn't be able to press his bell. I'm not sure what he'd do, maybe shout out and hope somebody hears him." A nurse told us that call bells should be left in reach for people who can use them. We talked to the registered manager who told us that people who are unable to use call bells are routinely checked every couple of hours and that they would speak to staff and make sure people who can use the call bells have them in reach. 'We asked if these checks were recorded anywhere, a Nurse told us, "No we have no documentation other than carers daily care record to indicate care provided to people." These care records only permitted four entries in a 24-hour period.
• The failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• The registered manager and staff understood their responsibilities to safeguard people from abuse however not all forms of abuse were understood by the registered manager and staff. For example, the home had many characteristics of institutionalised practice. For example, people were supported to start getting into their night clothes and into bed from approximately three pm. Several of these people did not have capacity to choose to go to bed in the afternoon and did not have best interest meetings in place surrounding this decision.

Inadequate

Is the service effective?

Our findings

People's care, treatment and support didn't achieve good outcomes, didn't promote a good quality of life and was not based on best available evidence

Effectiveness of care, treatment and support: outcomes, quality of life

Ensuring consent to care and treatment in line with law and guidance:
• 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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take specific 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 procedures 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.
• Where capacity assessments had been undertaken the outcome was unclear. For example, the assessments stated the person had been assessed, the outcome of the assessment for most people was 'not sure' and the final decision was that the person 'could' lack capacity. There were no best interest meeting minutes available and the registered manager was unable to demonstrate that best interest meetings had taken place. The MCA guidelines had not been followed and capacity assessments and best interest decisions were not taking place in line with the MCA. We spoke to a member of the management team about this and they told us that they were going to be improving the MCA and introducing best interest decisions. They had been given the Hampshire County Council MCA tool kit by a visiting professional but hadn't starting using it. We brought these concerns to the attention of the provider who after the inspection, provided an action plan with their actions to drive improvement around MCA. However, the submitted action plan noted that the actions stated would not be met until June 2019. It was therefore unclear, how in the interim, the provider was upholding people's human rights and adhering to the principles of the Mental Capacity Act 2005.
• Staff had not received MCA training. We found that some staff members demonstrated a lack of understanding about MCA and DoLS. One staff member told us that the MCA was the, "ability to make own decisions" and said they would refer to a nurse if they were unsure and another staff member said in relation to DoLS, "If they can't do anything we will talk about what they can't manage and it is really quite sad." Subsequent to the inspection, staff have received MCA training.
• DoLS authorisations were in place for five people, however two of these had expired. There was no evidence that these had been reapplied for. The registered manager told us, "We have got behind with DoLS, we need to apply for those going out of date. Another ten DoLS had been applied for, for those ten people, two of those dated back to 2015, with the remaining eight being applied for in 2017/18. There was no evidence of the DoLS applied for in 2015 being chased up. The registered manager was unable to demonstrate they had a good understanding of the MCA 2005.
• The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's needs were assessed prior to moving into the service, however there was no evidence that people's choices were taken into consideration. The pre-assessment form was mainly in a tick list format and did not contain information about how people would like to receive care and support with regards to their likes, dislikes and preferences. For example, people were not asked about their preferences around personal care or how they liked to spend their day. Care plans were not always evaluated effectively. For example, some monthly evaluation sheets contained boxes for staff to sign and print that they had been reviewed however contained no comments or documented evaluation.
• The provider did not always consider national guidance or standards. For example, The National Institute of Clinical Excellence (NICE) provides information about the management of medicines but this had not been followed. The registered manager was unaware of the Accessible Information Standard which sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss.
• Policies were not based on national guidance and best practice. This meant people's care and treatment may not always be delivered in line with the guidance and standards that support effective care.
• The failure to carry out an assessment of the needs and preferences for care and treatment of service users that takes into account nationally recognised evidence based guidance was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff skills, knowledge and experience:
• People and relatives told us the staff were skilled and competent.
• The provider monitored staff training on a spreadsheet matrix which gave details of when individual staff had completed training considered essential to their role. For example; infection control, food hygiene, fire safety, safeguarding, health and safety and, moving and handling. From the training documents provided we identified that staff had not received formal training in medication awareness, dignity and respect, person centred care, MCA, DoLS awareness or malnutrition and eating assistance. This meant that staff did not have the required skills to support people with these important aspects of their lives. This could result in people not receiving care that is personalised to them.
• Induction for new staff members was ineffective. New staff received an induction and were given an induction checklist to complete was two pages long and signed off in one day. New staff without prior care experience were not enrolled on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. New staff told us they shadowed a more experienced staff member until they felt confident to work alone and told us they found this period useful.
• Staff told us they felt well supported however they did not receive regular supervision and not all staff had an annual appraisal. Records were poor. For example, when supervision did take place none of the subject boxes were completed other than 'training' and 'action plan', the action plan was consistently recorded as 'Demonstrated safe practice – continue' A member of the management team told us, "I do get the documentation is not good, you are right about the documentation and I do want to change it." The registered manager told us, "Supervision I got told off for it last time this is the thing. Up until last time the inspector, (I was doing supervision every two months), said you only need to do it once or twice" and, "We put out a training programme every two months, we have a subject I speak to them or the deputy matron does it, we go through principles of what things say e.g. safeguarding." The lack of formal supervision meant that staff did not have a regular opportunity to meet with their manager, identify areas for improvement and feedback to the registered manager.
• Staff did not receive such appropriate support, training, professional development, supervision and

appraisal as is necessary to carry out the duties they are employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough with choice in a balanced diet:
•People said the food was good and that they had enough to eat and drink. People told us somebody comes around daily and asks them what they would like to eat the next day.
• We observed a tea trolley came around in the morning and afternoon, and people were offered choice of drinks and biscuits/cake/fruit. However, we observed drinks being taken to people's rooms. Tea was poured outside the room and taken into people, the carer said, "I have brought you a cup of tea," there was no choice in the type of drink people in their rooms were provided with. We have further reported on these concerns in the 'Responsive' section of the report.
• People said the food was good and that they had enough to eat and drink. People told us somebody comes around daily and asks them what they would like to eat the next day. People had access to drink throughout the inspection.
• We made observations during the lunchtime period. We observed that some staff stood up when assisting people with their meals. Staff mixed pureed food together, a practice which was not advised in their speech and language therapy report and fed people with a metal dessert spoon heaped with food. One person requested a small amount of food in their mouth but staff continued giving large spoonful's. This person did not eat much. Staff did not tell people what food it was they were having and there was limited talking with people. This meant that mealtimes were not a relaxed and social occasion, was not person centred and people were at risk of choking by being fed using spoons that were too large.
• Staff were task orientated. For example, once they had finished assisting people with their meals, they left the room, 10 minutes later we went through to the other lounge to find the member of staff sitting in an armchair talking to a colleague. This meant that people were left on their own after eating, not all people were mobile and required staff to support them to other areas or with personal care.
• There was a small dining room with a maximum capacity of six people on the ground floor which was not used at the time of our inspection. There was no dining room on the first floor. People who didn't eat in their rooms had their meals from a small chair using a small over bed table. Although people told us they didn't really mind where they ate, care plans did not record detail of where people might prefer to eat their meals. There were missed opportunities to ensure that mealtimes were sociable events where people could be encouraged to engage.'
• The failure to provide people with person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff providing consistent, effective, timely care:
• Staff told us they worked well as a team and described the handover process where they could pass on information to each other about people's changing needs.
• Staff did not always work with external professionals to ensure people were supported to access health services to support with their health care needs. For example, one person at risk of choking had not received a SALT referral since 2009. Despite these concerns, told us that they felt they could see the GP as and when they should need one. Records demonstrated that the GP visited people and that people accessed chiropody and attended hospital appointments.

Adapting service, design, decoration to meet people's needs:
• Peoples bedrooms were mostly dark and uninviting. The registered provider advised that some people preferred to use low light electric bulbs. During the inspection, the weather was observed to be sunny outside, however, many bedrooms still required the light to be on. Best practice guidelines produced by the University of Stirling dementia centre advises on the importance of lighting, especially for people living with dementia. No consideration had been given to the importance of lighting.

• Throughout the building were distinct signs of poor maintenance and décor. For example, carpets were thin and threadbare in some lounges and paintwork was chipped around every door frame. Walls in corridors were dirty and paintwork damaged.
• There was one room upstairs being redecorated at the time of the inspection. The registered manager told us they had to wait for a room to become vacant to redecorate it.
• The provider had started the replacement of carpets in the corridors and in two sitting rooms.
• The registered manager was unable to demonstrate that consideration had been given to making the home dementia friendly. Some doors had people's names on, however this was in very small writing. We asked the registered manager if any consideration had been given to a dementia friendly environment and they told us, "It is not different we go for friendliness, health and risk of safety." When we asked about supporting people to understand where their rooms were, the registered manager told us, "As far as I'm concerned, this home is secure for people with dementia" we orient people by seeing them and talking to them all the time, we know, but no different from any person that is elderly." This demonstrates a distinct lack of knowledge around guidance and best practice for supporting people living with dementia and demonstrates a fundamental lack of person centred care. This was a failure to follow best practice guidelines. For example, the Social Care Institute for Excellence (SCIE) and National Institute for Health and Care Excellence (NICE) dementia guidelines.
• The failure to provide people with person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

The service doesn't involve and doesn't treat people with compassion, kindness, dignity and respect

Treating people with kindness, compassion, dignity and respect

Ensuring people are well treated and supported:
• People said they were treated kindly by staff. Most people told us that staff communicated well and knew them well. One person told us, "Staff are very nice, they are caring. They dress me nicely and keep an eye on my bruising, I have lots on my legs," another person told us they felt staff did take into account their needs regarding communication, staff usually made sure they put their glasses on and had hearing aids in. However, whilst some relatives felt communication was positive and effective within the service, some relatives raised concerns about communication. For example, one relative did not know if their relative had baths although they did comment that they presumed they did because they provided toiletries and did not smell. Another relative found, communicating and arranging their relative's haircut, to be a difficult process and a third relative was unaware if their relative's medical intervention was a permanent process and commented that staff did not tell them anything.
• Despite people's positive comments about the staff team, we identified areas of practice which were not consistently caring. The provider had not ensured people were adequately supported in terms of protecting their rights, ensuring that risks and medicines were managed safely, providing stimulating activities and ensuring people could provide feedback about their care and the service which was acted on. We have discussed the associated risks of this within the 'Safe', 'Effective', 'Responsive' and 'Well-led' section of this report.

Supporting people to express their views and be involved in making decisions about their care:
• There was no evidence to suggest that people had been supported to express their views. For example, no one was asked how they wished to spend their time during the day of inspection. People's meetings did not take place and people were not involved in decisions about their care and treatment. People told us they were not told about sources of advice and advocacy that may be available. There was no evidence in care records that people had been involved in decisions about their care. We discussed our concerns with a member of the management team, and they told us people should be involved in care planning and risk assessments, they said, "I have thought about going through files with family and people." This meant that people did not have an opportunity to feedback on their care and support.
• The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The manager was not able to provide any examples of how this act was adhered to. The failure to provide people with person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Respecting and promoting people's privacy, dignity and independence:
• Staff were able to tell us how they would protect people's privacy and gave examples such as closing doors and curtains when assisting with personal care. However, we observed during the inspection that staff did

not always knock on people's bedroom doors before entering. This meant that people's privacy and dignity was not being maintained.

• The Equalities Act 2010 is designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. There was no evidence that people's preferences and choices regarding these characteristics had been explored with people or had been documented in their care plans. We discussed our concerns with the registered manager and they told us, "Well it would be written on the bottom if they had anything." We asked, 'Do you ask about people's sexuality', the registered manager told us, "We certainly would not say that on the assessment, we are meant to treat them all alike so we wouldn't, we need to treat for their needs and requirements not to do with diversity or their sexuality." This demonstrated that the registered manager did not consider equality, diversity and human rights and lacked an understanding of the Equalities Act 2010. failure to provide people with person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that responded to their needs

How people's needs are met

Personalised care:
• There was no evidence that people were empowered to make choices or have as much control and independence as possible, including developing their care and support plans. One person told us, "Care Plan, what is that? Never heard of one."
• Care plans were not person-centred and lacked information about people's needs, wishes and preferences. For example, assessments did not provide detailed information, consequently care plans lacked detail in many aspects of how to best support nurses and carers in providing best, evidence based care for people.
• People who had interests were encouraged to continue them, for example, one person had been part of a French speaking group for years and now the group come into the home to meet with him. They told us, "It's great, we have the small room downstairs overlooking the garden every Monday night for a few hours." Another person liked the royal family and had made scrap books with newspaper cuttings which they kept by their chair in the lounge. They also enjoyed knitting.
• People were at risk of social isolation, for example; The activity coordinator told us, "Some people join in all activities but most like to stay in their rooms." At least 12 people residing at Fieldgate Nursing Home spent all day in their bedroom. Documentation failed to reflect that this was people's own preference and how the risk of social isolation was mitigated. People were supported to go to their bedrooms and change into their nightclothes from approximately three pm. Observations on the day of the inspection identified that activities were centred around people who could physically engage. People who remained in their rooms appeared socially isolated and not engaged in any meaningful activity for the majority of the time. There were three activity coordinators all together two of whom were part time. We spoke with one of the activity staff who said that there was no engagement with the local community. There was no weekend or evening activity coordinators. There were no planned group activities taking place on the day of inspection.
• Two people talked about Christmas shopping last week and had a meal out too. They said, "It made a very nice change" and, "I love being able to choose my own Christmas presents for family. One of the nurses is coming to help me wrap them up next week". There was a planned pantomime show. However, a lack of space in the service meant the lounge area would be unable to accommodate many people attending and there was no room to enable a person who was bedbound to engage with this or any other activity in the lounge. The registered manager told us that during the pantomime people who remained in bed are, 'visited during the pantomime by Father Christmas and his Elves with gifts in his sack.'
• Some areas of daily activity were task led by staff. For example, people had a bath on certain mornings depending on what room number they were. The manager confirmed that there were no showers available. Not all care plans detailed when people wished to get up or go to bed, where they liked their meals or how they liked to spend their day.
• One person told us that a male carer sometimes deals with her personal care and she really doesn't like it. We spoke to a member of the management team about this, she told us, "A few ladies like females because they have told us." The registered manager told us they know who would like female support because

people tell them. When asked if people were asked their preference and where this was recorded they told us, "I think it is something we ask, we find out these things, it isn't recorded anywhere." The registered manager said they could add it to the assessment but didn't seem to understand why this should be documented.
• Care plans did not highlight the need to offer people choice and did not actively encourage people's involvement in everyday aspects of care provision. This was evident from the bathing rota. Each person was listed and they were allocated a nominated day for a bath. We asked one of the carers if the two-people identified for bathing on Tuesday had been supported with a bath. They told us that very few people go into the 'big bath' and are instead given a bed bath and hair wash in bed on their identified day. This was task orientated and did not allow people choice or permit flexibility according to day to day needs of people who use the service. Of the 32 people who lived at Fieldgate Nursing Home, approximately 28 were supported with a bed bath. We spoke to the registered manager about this and asked if people had the opportunity to have more than one bath a week, she responded, "They can do, let me get the bath rota for you." The bath rota did not identify anyone who had more than one bath a week. The registered manager told us this was their choice however there was no evidence that people were offered more than one bath a week and care plans did not promote this choice.
• A member of the management team told us that approximately three people were nursed in bed and a further nine people stayed in their rooms however these figures could change daily. Some rooms did not have a chair or the space to locate a chair if the person wanted to get up. Staff told us that some people frequently remained in nightwear and in bed all day rather than being actively encouraged to engage in daily life. There was no evidence to demonstrate that people were given a choice regarding this decision. We observed throughout the inspection that staff started to support other people who were in the lounge to their bedrooms and into their night clothes from 14:30 onwards. People told us they go to bed usually by teatime. Nobody that we spoke to complained about this. However, one person said it was a long time to be in bed in the same position from six pm until sometimes ten am the next day as they don't move much in bed. This person told us "I don't mind going to bed at six pm but I would like to get up a bit earlier" They told us they do not always have their continence aid changed in the night and said, "I was wet through this morning, which isn't comfortable." We discussed our concerns with the registered manager who told us, "They like to get their pyjamas on, they like to have tea in bed and to be quite honest so would I." This demonstrated institutionalised practice.
• The failure to provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:
• People told us they knew how to raise a concern, they said they would tell a member of staff.
• We asked how are lessons learnt and shared across the service, the registered manager told us, "Talk to all the staff we talk really quick to each other. I discuss in a meeting." We pointed out that team meetings only occur yearly and the registered manager told us, "I tell them." There was no documentation in place therefore we could not be assured that lessons learnt were shared consistently.
• We viewed the complaints log and saw that some people's complaints were responded to however we could not be assured that they were resolved for people. There were complaints logged with no detail about any action taken therefore there was no analysis of complaints to identify themes or make improvements at a service level. The same complaint was received from a relative on 6 August 2018 and 27 August 2018. Where investigations took place, there was no detail of the outcome. This meant that there was no system in place to see how people's concerns had been addressed or to understand any emerging themes or patterns of people's concerns.

End of life care and support:
• People did not have end of life care plans in place when they were receiving end of life care. The registered

manger told us that people do not want to discuss funeral plans at the end of their life. This meant that staff were not aware of people's preferences at this time. Best practice guidelines around end of life care was not being followed.

• The failure to provide care and treatment of service users that was appropriate, met their needs and reflected their preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

• Most staff had not received training on end of life care, however, healthcare professionals were involved as appropriate.

• People's families were supported while people were receiving end of life care.

• The service sourced specialist equipment and medicines at short notice to ensure people were comfortable and pain free.

Inadequate

Is the service well-led?

Our findings

Leadership and management of the service did not assure person-centred, high quality care and a fair and open culture. There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• The registered manager had been working for the provider since 2005 and in 2010 became registered with the Care Quality Commission, following a change in legislation. At the last inspection in August 2016, the provider had not carried out its statutory duty to complete a notification and send it to CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection this had improved and was no longer a breach of the regulation.
• We found the quality assurance processes to be ineffective and did not pick up on the issues identified at inspection. These included concerns with recruitment, records, risk management, medicines and a lack of person centred care. Care plan audits had not taken place since September 2017. We discussed our concerns with the registered manager and, they told us, "I knew in 2012 that evidence was a big thing for the KLOEs, I know auditing was the way to go. We did it [Care plan audits] in 2015, it went on to September last year. [Company Employee] comes in twice a week and looks at paperwork and writes down what she's done. She hasn't looked at care plans because she has been working on rota's."
• Medicine audits were ineffective and did not identify the concerns we found during the inspection. Numerous concerns were identified with records. These included incomplete care plans that lacked detail, risk assessments that were not detailed and inaccurate information in the controlled drugs book, and a lack of clear detailed monitoring charts for people.
• We found that not all risks were identified and acted on to monitor the safety and quality of the service people received. For example, we reviewed the 'daily care record' for one person. This person had been commenced on a turn chart to increase the frequency of their turns. We reviewed the following care plans; safety and risk, safer manual handling, mobility and dexterity and night hours, none indicated why this had been initiated and had not been updated to reflect the need to turn every four hours. We looked at the case file for this person to review epilepsy, learning disabilities and cerebral palsy care plans or evidence of care plans that supported the people around these aspects of their care needs. There were no care plans available in relation to this.
• There was a risk that if robust records were not put in place, this could negatively impact on people's health, safety and well-being. A failure to have effective systems and processes in place to monitor and mitigate risks to people and maintain an accurate, complete record in respect of each service user was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong:
• Person-centred care was not promoted in the service and people did not always receive high quality care. This has been demonstrated in the other domains of this report. One relative did not feel the service communicated well and would like this to improve. They told us, "I am the main point of contact for my

father and they hardly ever phone me. I do not know what goes on when I'm not here but once I noticed some bruising on dad's hand which they hadn't told me about."
• Staff told us they felt supported and valued by the registered manager and the deputy matron.

Engaging and involving people using the service, the public and staff; Working in partnership with others:
• There were no records that demonstrated people or their relatives had been involved in decisions about their care or the running of the service. Surveys to gain feedback about the service had been sent out in 2017. There was an evaluation at the end of the survey results however this did not cover all areas raised by family members.
• The registered manager told us that a meeting for people had taken place with the deputy matron while she had been absent however was unable to provide minutes of this meeting. A member of the management team told us that they wanted to introduce people and relative's meetings on a regular basis.
• There was limited opportunity for people to feedback and there was no recorded action about how improvements had been made or were planned. The registered manager told us, "Sisters (nurses) meetings are one a year and carers meetings are every 12 to 18 months, yearly if we can fit it in," there was no recorded opportunity for staff to feedback during these meeting and no action plan following the meetings. This meant that the views from people involved with the service had not been considered or acted upon to make improvements.
• The registered manager told us that there were very few links with the local community but said, "A church group does come in, a couple of different churches. I don't know if [person] was going out to some place."

Continuous learning and improving care:
• The service had minimal audits and no action plans or improvement plan in place which meant improvements could not be made.
• The registered manager did not keep up to date with legislation and best practice guidelines. For example, the safeguarding file had details regarding 'no secrets', 'POVA' and CRB which have been repealed and replaced by current legislation. The registered manager told us they keep up to date from the "Registration of Nursing Homes Association, they normally tell us, they haven't said POVA isn't used anymore, we still ask for POVA checks."
• Both the registered manager and the management team had limited knowledge of the MCA and the DoLS process and who it applies to which has been referred to within the 'Effective' domain of our report. Understanding of Equality diversity and human rights was limited for the Registered Manager
• The registered manager had no understanding of guidance and best practice for supporting people living with dementia and both referred to people living with dementia as 'the dementias."
• The registered manager told us "There is always room for improvement," however felt they were doing a good job. This demonstrated that the registered manager lacked the understanding and competence to manage the service
• A failure to have the necessary competence and skills to manage the carrying on of the regulated activity was a Breach of Regulation 7 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing • Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to provide care which reflected people's preferences. Regulation 9

The enforcement action we took:

We imposed a condition on the providers registration requiring them to audit the service on a monthly basis and provide CQC with a written report about their progress in making the improvements needed and ensuring this regulation is met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks were assessed and effective plans implemented to mitigate these and a failure to ensure safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed a condition on the providers registration requiring them to audit the service on a monthly basis and provide CQC with a written report about their progress in making the improvements needed and ensuring this regulation is met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to asses, monitor and improve the quality and safety of the care delivered. Regulation 17.

The enforcement action we took:

We imposed a condition on the providers registration requiring them to audit the service on a monthly basis and provide CQC with a written report about their progress in making the improvements needed and ensuring this regulation is met.