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Polefield Nursing Home

Inspection report

Polefield Nursing Home
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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?	**Inadequate**

Summary of findings

Overall summary

The inspection was carried out on 05 and 10 October 2016 and the first day was unannounced.

The previous inspection took place in April 2016 where eight breaches of the Health and Social Care Act 2008 were identified. The provider was rated as Inadequate and placed into special measures by CQC. We took enforcement action after the last inspection. This inspection was carried out to check on the improvement actions identified in the provider's representations.

Polefield Nursing Home is a service providing accommodation and support with personal care to a maximum of 40 people who may require nursing or residential care. The home is over two floors and has a passenger lift. There were four rooms on each floor which are double occupancy rooms. There is a communal lounge and dining room on each floor. The home is set back off a main road, with level access grounds. There is a large garden area which people can access. At the time of our inspection, 31 people were living at the service, 13 on the nursing floor and 18 on the residential floor.

At our last inspection we found the service to be in breach of some of the regulations, at this inspection we found the service was still in breach of some of these regulations. Due to these continued breaches the service continues to be inadequate in well led. This meant the service remains in special measures.

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

The service did not have a registered manager. There had been no registered manager in post since March 2016. The provider intended to register as manager, but at the time of the inspection had not yet begun to undertake this role. 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.

When we arrived at the service, we found the service was not displaying their rating from our previous inspection. All services are required to display this rating both within the service and online if they have a website.

People felt safe with the care and support they received. Staff were aware of the safeguarding process and how to report any concerns they had. However not all staff had received up to date training in safeguarding adults and we found the policies and procedures staff were required to follow, remained out of date.

Risk assessments were in the process of being updated and becoming person centred. However not all of the identified environmental risks were being monitored as required which meant people were still at risk

from harm.

Staff sought consent from people before providing care or support. The ability of people to make decisions was being assessed in line with legal requirements to ensure their liberty was not restricted unlawfully. Decisions were taken in the best interests of people when necessary and the service were completing assessments on people's capacity.

Care plans were being updated at the time of the inspection. The care plans we viewed were more person-centred and had been reviewed. However, it was not clear if people had been involved in writing the updated care plans. Pre-assessments included people's likes and preferences and staff knew the people well.

Medicines were not always administered safely. We found staff on the nursing floor were not always signing when they had offered medicine which was 'as and when required'. Some of the staff had recorded when people had refused the medicine, but this was not consistent and they had not recorded a reason why the person had declined it. The manager of the service had already identified this during previous audits, but no action had been taken.

People were well cared for and found the manager had brought in additional staff for the busy morning period, but the duty rota showed staffing levels at night and at the weekend to be insufficient to support them effectively. The staff were knowledgeable about the needs of the people and knew how to spot signs of abuse. The recruitment process was not robust and sufficient checks had not been implemented prior to staff commencing work.

Not all staff had completed training appropriate to their role. Staff were observed as being kind and caring, and treated people with dignity and respect. They spoke to people with respect. There was an open, trusting relationship between the people and staff, which showed that staff knew people well.

People were supported to access activities within the home; those who were cared for in their beds had time allocated for one to one support. People were able to make choices about how they spent their time and where they went each day.

We saw people and their relatives had been asked for feedback about the service since our last inspection. Staff meetings were being held. There was an open and transparent culture which was promoted amongst the staff team.

Policies and procedures had not been updated and were out of date and were not being followed. Quality assurance checks had been completed in some areas but not all.

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.

Not all staff were following the policies and procedures in line with infection control.

The service was not taking appropriate action to minimise the risks against people living at Polefield Nursing Home.

The administration of medicines was not always recorded, we found gaps in people's medication administration records.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received appropriate training in order to be able to carry out their roles.

Capacity assessments were now being completed and the Mental Capacity Act was being followed.

Referrals were being made to healthcare professionals when a need arose.

Is the service caring?

Requires Improvement

The service was not always caring.

Care files and documents about people living at Polefield Nursing Home were not always kept securely.

All staff were kind and caring and treated people with dignity and respect.

People's end of life had been considered, however we did not see records of where this had been discussed with the person

Is the service responsive?

Requires Improvement

The service was not always responsive

There had not been a recent residents meeting, but people knew how to make a complaint.

Staff knew what person-centred care was and care plans were being updated to reflect this. However it was not clear if people had been involved in the writing of their care plans.

People were supported to join in group activities and those who were unable had access to one to one activity time.

Is the service well-led?

Inadequate

The service was not always well led.

The service did not display their rating from the previous inspection which they are required to do so.

The service did not have a registered manager in post, but staff felt supported and regular staff meetings were now being held.

Policies and procedures had not been updated, but the service was now completing some quality assurance checks.

Polefield Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 10 October 2016 and the first day was unannounced. The inspection team consisted of two inspectors on the first day and one inspector on day two.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. 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. This was because the service had recently been inspected. We reviewed the information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people, two family members, and the provider who is also acting as manager, five care staff and an apprentice. An apprentice is a person who is learning a trade from a skilled employer, having agreed to work for a fixed period at low wages. We observed the way people were supported in communal areas and looked at records relating to the service. Including seven care records, seven staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Polefield Nursing Home on 18 and 20 April 2016, we found infection control processes put people's health and welfare at risk. When we arrived at the service we found that the external waste storage area was unlocked, and waste bins were overflowing. There were discarded plastic aprons and gloves lying on the ground. As well as yellow clinical waste bags lying on top of bins, on the floor and piled high in the storage bins so the lids did not shut properly, meaning vermin could get into the bins. The kitchen waste bin was being kept outside the kitchen fire escape door, blocking access should there be a fire.

At this inspection on the 5 and 10 October 2016, we found that the waste bin area was now secure and kept locked, with chicken wire over the top to prevent vermin accessing the bins. However, on arrival for the first day of inspection there were four yellow clinical waste bags on the floor outside of the clinical waste area. We discussed this with the provider, who told us that the member of night staff had not known the code for the lock in order to access this area. We saw they were removed within 30 minutes of us arriving at the service. We will continue to monitor this to ensure improvements continue.

At our first inspection on the 18 and 20 April 2016, we also found staff were failing to follow safe infection control policies and procedures. We saw staff members wearing their long hair down whilst providing care and support. There were a number of staff members observed wearing rings containing large stones as well as wearing bracelets. Both of these could cause harm to a person, potentially causing bruising or a skin tear, as well as being an infection control risk. At this inspection staff were seen to be wearing their hair up, however we still saw some staff wearing rings with stones in and wrist watches which could still put people at risk from injury or infection.

At the inspection on 18 and 20 April 2016, we saw staff leaving red laundry bags which are used to transfer contaminated/soiled items on the floor beside the lift. Staff were also seen bringing clean laundry out through the entrance used for taking in the dirty laundry in. Infection control guidelines state that dirty laundry should arrive through one door and be removed through a separate exit to a clean area. This was not happening and put people at risk from infection. We also found that the laundry area was kept unlocked meaning people had access to cleaning products which could cause them harm. Consequently, people were not always supported to live in an environment where infection risks were effectively managed.

At this inspection we found the entrance to the laundry room was still being left unlocked but we were told by the provider that clean clothes were now being taken out through a separate door which was kept locked. We did not observe clean clothes going out of the laundry this way, however a staff member we spoke with, confirmed they were. We saw that people were still accessing the garden through the laundry area where bottles of detergent was being stored on the floor. This continued to put people at risk from harm. We also found the cleaning store cupboard which contained various cleaning products, was left unlocked during our first day on inspection.

Failing to store cleaning products securely was a breach of regulation 12 (2)(b) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection, we looked at the administration, storage and disposal of medicines. At our previous inspection we found the practice was not safe as medicines were being potted up and signed for, prior to being administered. We also found evidence of secondary dispensing. On this inspection we found medicines were no longer being signed for prior to them being administered and there was no evidence to suggest that medicines were being secondary dispensed. However, we did see staff 'popping' the medicines out of the blister packs to take to the person in a medicine pot instead of taking the trolley containing the blister packs. It meant the staff member did not have the person's medication administration record (MARs) to sign or refer to check if the person required any additional medicine. We found on both inspections that there were no protocols kept with the MAR's for people needed 'as required' (PRN) medicines or required their medicines to be given covertly. Not keeping the protocol with the MAR meant that the person administering the medicines had to go to the care files and look through them in order to follow the advice recorded. This would impact on the time taken to administer the medicines and could result in staff not offering the medicines when they were needed.

Not all of the MARs had a photograph of the person who the medicine was prescribed for. Having a photograph allows staff members to have an additional check to ensure they are administering the medicines to the correct person. We also found that staff were not always completing the MARs for people who were refusing or declining the PRN medicine. When staff had recorded in the MAR the person had refused or declined it, they had failed to provide details for the reason. This meant there was no record of whether the person was always being offered the PRN medicine, or the reason it was being refused. We discussed this with the provider who was aware of the issue but could not provide a reason for this continuing to occur. This concern had been raised previously and the provider was aware that it was occurring, yet appropriate action had not been taken to prevent it from happening despite staff members being competency assessed on administering medicines.

Not ensuring that staff were completing accurate records of peoples medicine administration was a breach of Regulation 12 (2)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 18 and 20 April 2016, we found risks to people had not always been assessed and managed safely. Risk assessments had been completed but were generalised and did not show the risks to each individual person. We found risk assessments had not always been reviewed and we found that they had not always been updated. At this inspection we viewed seven care files and found they were being updated and some we viewed were noticeably more person centred. We discussed this with the manager, who explained that they were in the process of trying to update everyone's care file and get staff to write the risk assessments rather than just print off generic assessments and write the person's name on. We saw evidence to show this was happening, but not everyone living at Polefield Nursing Home had a personalised risk assessment. We will continue to check this to ensure improvements continue.

At the previous inspection we found the service was carrying out environmental risk assessments such as gas, electric and temperature checks on the water system, but we saw no record that this was being completed in rooms which were no longer being used, but still posed a risk. For example, some of the bedrooms which were currently unoccupied and also some of the old bathrooms which didn't appear to be in use as they housed equipment.

At this inspection we found the water still wasn't being checked in the unoccupied rooms and could find no record of water checks throughout the building being undertaken since our inspection in April 2016. These checks should be completed weekly to ensure the water temperature is safe. We spoke to the provider

about this who told us the handyman was carrying out the checks on the first day of our inspection. We did not see any record of this despite seeing the handyman in the building and asking the provider for copies of the previous water checks as well as. Following our previous inspection, the provider had sent an action plan and representation stating that water checks were completed weekly. However we saw no record of these despite asking for copies from the provider.

Previously we had raised concerns about the wardrobes being freestanding, we saw these had been attached to the wall securely to prevent them being pulled over. We also noted that all the electrical switches which were broken had been replaced. Previously the radiators in the service did not have covers over them , we found that all of the radiators except for the ones in the stairwells, had radiator covers over them. We identified that the radiators in the bathroom had been covered, however they hadn't been finished off, leaving sharp edges and corners which could cause injury. We discussed this with the provider who said they hadn't had time to complete them all fully. We questioned whether the bathrooms were being used as the exposed medium-density fibreboard (MDF) that was used to box in the radiator and pipes, would warp and could not be cleaned sufficiently meaning they posed a risk from cross contamination. We raised this with the provider who stated they would be covered like the ones in people's bedrooms, but they hadn't had time to complete. At our previous inspection we had raised concerns about the service not having window restrictors fitted to the windows on the ground floor and in the stairwells. We found the service had install them in all areas identified apart from the downstairs dining room. This had previously been raised with the provider as it posed a risk that a person could enter the building undetected. We discussed this with the provider who could not answer why it still had not been fitted, other than saying, "time".

At our previous inspection we had also found the service did not have risk assessments in place or safe systems of practice available for staff to follow in relation to areas such as fire safety. There was no business continuity plan in the event of a major incident. The personal emergency evacuations plans (PEEPS), lacked detailed information about each person's support needs and abilities and there was no separate file containing the PEEPS, which staff could access easily in the event of an emergency such as a fire. This could put both staff and people at risk from injury or harm as the emergency service personnel would not have details about each person and how they may react in the event of having to evacuate people from the building. On this inspection, we found the service now had a file containing PEEPS for each person living at Polefield Nursing Home and provided details about their abilities. It also contained floor plans for both the nursing and residential floors, showing where the fire escapes were as well as the 'safe zones' in the event of a fire. The service also had a business continuity plan in place, which provided details about actions staff needed to take in the event of an emergency.

This showed the service was now identifying some risks and was in the process of taking action to minimise them. However, they still had not taken action to address all the risks which had previously been raised.

At our previous inspection we found staff recruitment was not safe and there were insufficient staff on duty. At this inspection we found the staff recruitment files had been updated. They all contained application forms and full-employment details. We saw checks had been completed with Disclosure and Baring Service (DBS) prior to staff starting working in the service. The DBS is carried out to ensure staff are suitable to work with people who live at the home. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We saw that two references had been obtained for each staff member however these were not always the person's last employer. One reference we saw from a previous employer for a staff member who was new to the service, indicated that they would not employ the person again, but gave no reason for this. Comments made about this person's character were judged to be good or satisfactory but the provider had not explored with the referee why they would not re-employ this

person. This showed the service was still not carrying out sufficient checks to ensure a person's suitability to work at the service.

We previously identified there were insufficient numbers of staff on duty at Polefield Nursing home. We found there was one senior carer and two care staff to support people in the morning, which meant when the senior carer was administering medicines, there were only two members of care staff to support people on the residential floor and on the nursing floor it was similar with a nurse and two members of care staff on duty. At this inspection staff told us that there were more staff on duty on the residential floor during the busy morning period. One staff member said, "It's much better now, especially in the mornings." We saw that as well as the senior carer, there was also two care staff members, and apprentice as well as the activities coordinator. An apprentice is a person who is learning a trade from a skilled employer, having agreed to work for a fixed period at low wages. We discussed this with the provider who explained they were now using a dependency tool to determine staffing levels. We looked at the staff rota and saw that despite this increase in staff numbers, there did not appear to be sufficient staffing levels on duty at the weekend and also at night. This was discussed with the provider who explained they did not record when they [the provider] had covered a shift or when they had used agency staff members on the staff rota. This meant the service had no evidence there were sufficient staff on duty during those periods of time. At night there were two staff members on duty on each floor which would not be sufficient as some people living at Polefield nursing home required two staff members to meet their need. This would mean that at times overnight, there would be no staff available to meet the needs of other people living at the home. The provider also told us that there were no senior care staff on duty on the residential floor, meaning that all medicines had to be administered prior to the afternoon staff going off duty. This could mean people were not receiving their medicines at the correct time and if anyone required any medicine overnight, then the nurse from the nursing floor would have to go upstairs to administer them.

The failure to ensure there were sufficient staff on duty was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe with the care and support whilst living at Polefield nursing home and staff were able to describe how they kept people safe. Staff members were able to describe different types of risks which may pose harm to those living at Polefield. All care staff we spoke with knew what to do if they suspected abuse and who they would report it to. However we found out of 38 staff members only 14 had received a refresher in their safeguarding training according to the copy of the training matrix. This meant that despite staff knowing what signs to look out for and actions to take; they had not received information on recent changes with regards to safeguarding. We found the policies and procedures for safeguarding and whistleblowing had not yet been up dated and remained out of date. We saw that accidents and incidents were being recorded and reported appropriately to the local authority and the Care Quality Commission.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found staff had not received updates in essential training as they are required to do so. We saw that essential training in areas such as fire safety; infection control and safeguarding had only been completed by a few staff. On this inspection we found this to still be an on-going issue. Of the staff employed at the service, the training matrix showed that only 10 staff members had received refresher training in fire safety in June 2016 and only 9 staff members had undertaken training in COSHH and continence care. None of the domestic staff employed by Polefield nursing home had received training in infection control. The provider had failed to ensure the staff had received the appropriate and essential training in order to provide effective care and support to people living at Polefield Nursing Home.

The failure to ensure all staff were appropriately trained to carry out the role safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff showed an understanding around consent. We saw that before people received any care or support, staff asked for their consent and acted in accordance with their wishes. Staff had a general understanding of the Mental Capacity Act 2005 (MCA) and how this impacted upon the work they did but had not received any training in this area. Where people required bed rails to be fitted to their beds in order to prevent them from falling out of bed, we saw their care files now contained risk assessments for these and where possible people had given their consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that some people living at Polefield nursing home were subject to DoLS authorisations and those applications had been submitted for other people living at the service. The provider told us and we saw evidence to support, those with DoLS authorisations in place had been supported by independent mental capacity advocates to ensure the decision being made was in their best interest. We also saw one person had an advanced decision recorded in their care file. This had been completed on their admission into Polefield nursing home. We saw this had been reviewed in line with the services timescales and it was noted this person no longer had the capacity to be involved in the updating of their care plan. We saw the provider had applied for a DoLS in relation to this person and there was a standard authorisation in place.

Staff were aware of people who required a specialised diet and the reasons why they required it. People had been involved with the menu planning and the meals we saw appeared to be nutritious. We had mixed

views about the food. Comments included, "It's awful, I don't want it." Another person said, "I'm fed up of frozen stuff." Whereas a third person told us, "I had jacket potato and cheese last night; I asked for it and got it." A staff member told us, "Food is now fresh. It used to be frozen [and there are] new menus now." We heard people being offered a choice of foods on offer that day, or other options if they had a favourite food. Or did not like what was on offer. One person was offered several vegetarian options for both lunch and tea and we saw that staff recognised people's preferences. We observed the mealtimes and saw they were now sociable occasions. More people ate in the dining room but people still had the option of eating in their room or in the lounge. We saw new menus had been devised and were on a four weekly rota. The provider explained that there were always two choices, however the nursing unit was offered one of the choices and the residential unit the other. If the person did not want what was on offer on the nursing unit, they then had the choice of what was on offer on the residential unit and vice versa. This meant the person had choice however; people would have to know to ask for it making it not a person friendly way of offering choice.

People had access to doctors and referrals were made to speech and language therapists (SALT) when required. We spoke with a visiting physiotherapist who had been contacted by the service as staff had identified deterioration in a person's ability to mobilise and undertake daily activities. We also saw a person who had come to the service for a period of respite and received an access assessment for the occupational service and the person was receiving professional input to improve their mobility. We also spoke with a visiting district nurse, who described the service as being "responsive" and the staff as "Being on board". Care files we checked showed when referrals had been made to healthcare professionals and the reason they had been made.

Requires Improvement

Is the service caring?

Our findings

We observed caring interactions between the people, their relatives, care staff and other professionals. Staff knew who they could engage in banter with, and those who required a more sensitive or formal approach. Relationships between the staff and visitors were warm and friendly and there were no restrictions on people having visitors. Staff showed concern for people's wellbeing in a caring and meaningful way. One relative we spoke with said, "They're very good here. Staff are great. All the carers are very good."

People's privacy was not always protected. We found the filing cabinet which contained all of the care files for people on the nursing unit was not kept locked. We spoke with the provider about this who told us the key "had been lost". The filing cabinet was being kept in the main foyer of the home which could be accessed by anyone visiting the service. We also found diaries and other information about people who lived in Polefield Nursing home, was being kept unsecure, on the desk in this area. As we went round the service we found the doors to the rooms on the top floor, which was an area used by only staff and the manager, were not kept secure meaning anyone was able to access the rooms up there along with archived information about people. We raised this with the provider who agreed with us that this was not safe, however they did not provide us with any information about actions they were going to take to prevent this from happening.

The failure to ensure that all records were stored securely was a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 Regulated Activities) Regulation 2014.

At the previous inspection we found the service was using pressure mats, taped down with 'gaffer' tape on the floor in front of doors which led to the stairwell. On this inspection we found the service had removed these pressure mats and replaced them with door alarms, which sounded every time the door was opened. This meant they sounded whenever staff went between the nursing and residential floors. These were being used to alert staff to a particular person who resided on the residential floor, who wandered and potentially could be at risk from falling down the stairs. However, we noted that this alarm was not only very loud, the door was slow to close and so it went on for some time. Also, because it sounded every time the door was opened it would disturb people whose rooms were near to the doors. We discussed this with the provider as it did not respect people's right to have a peaceful undisturbed sleep.

Within some of the care files we looked at we saw people had do not attempt cardio pulmonary resuscitation (DNACPR) forms had been completed and in some instances people had a statement of intent form to allow the GP to issue a medical certificate for the cause of death. The one we viewed had not been reviewed since April 2014. This meant the person's needs could have changed and the information held on file was not up to date. We did not see any care plans showing people's wishes with regards to their end of life care. The provider and a staff member were currently undertaking training towards the six steps end of life pathway. The six step end of life pathway was produced by The National End of Life Strategy (DH 2008), to highlight the six steps required to provide good end of life care. This meant the service was not ensuring people's end of life wishes were being met, however, we were saw that the service was in the process of updating people's care files to make them more person-centred.

Staff were seen protecting people's dignity by always knocking on people's doors before entering. Staff told us of the practical steps they took to maintain people's dignity such as closing doors and curtains when providing personal care. We saw a person was supported from the lounge to their bedroom for an appointment with the district nurse. The staff member kept the person fully informed about what they were going to do and when, in relation to using the hoist and sling to transfer the person to a wheelchair in order to move them to their room. The staff member spoke with the person in a calm manner and discreetly showing they respected the person's dignity.

We noted the television was on in the residential lounge very early in the morning and was quite loud at times due to the content of the programme. Three people who were in the lounge did not appear to be watching the television. When a staff member came in to start activities, they asked the people in the lounge if they minded if the television was turned down as one person who appeared to be reading had the remote control. We asked the person who was reading if they chose to have the television on as they were reading and they told us, "Yes, I like the back ground noise." This showed the staff respected people's wishes and asked before taking action.

Staff knew the people they were supporting and this showed in the way in which they provided their care and support. For example, one person liked to go out shopping. We heard a staff member ask if they wanted to go to the shops after they had finished what they were doing. Staff were able to describe people's individual needs, preferences and choices. Staff were able to describe to us how they promote the independence of people by encouraging them to do as much for themselves as possible and not take over. People were supported to be as independent as possible to the full extent of their abilities. They were able to move freely around the house and choose where they spent their time. Staff encouraged people to make choices for themselves; we observed staff asking people if they wanted to participate in activities and waited for a response from them.

Requires Improvement

Is the service responsive?

Our findings

We asked people living at Polefield Nursing home if staff responded in a timely manner and they told us, "Yes, quite quickly when they're not busy."

There were three people sitting in the residential lounge on the first day of our inspection. We asked one person if it had been their choice to get up early. They told us they liked to get up at 7am and said, "I like to be on my own, nice and quiet." Staff were able to give examples of what was important to particular people and a fairly new staff member told us, "I know a lot about each resident. I know what they would prefer." Another staff member told us, "If someone new comes in I read the care plan."

Staff knew what person-centred care meant and could describe how they provided it. They knew people's likes and dislikes and were knowledgeable about people's individual needs and how to ensure these needs were met.

People told us there used to be residents meetings held, however these had not happened recently. One person told us, "No resident meetings. There used to be." We asked people what they would do if they needed to raise a concern or complaint. People told us they knew how to make a complaint and one person told us, "I've not made a complaint. I've nothing to complain about." There was a formal complaints procedure in place and there were notices on the walls of the service, advising people how they could make a compliant. Since our last inspection the provider informed us they have sent people and their relative's feedback forms. We asked for these and saw that the service had received four completed questionnaires in relation to the service being provided.

At our previous inspection in April 2016, we found people's care plans were generic, with blank spaces to insert a person's name and used the terms his/her. They were task orientated and not personalised to the individual preferences of the person. At this inspection we found, care plans were being updated and were more person-centred and reviewed monthly. However from the care plans we viewed, it was not clear if people had been involved in writing them. We did see recorded in one care file where a family member had been involved in the review of one person's care plans. We spoke with the provider who was in the process of updating people's care files and who intended to involve both people and their relatives at their next review.. We will check this at our next inspection.

One care plan we saw was in relation to a person's specialised diet. It documented the person required 'fork mashable' diet due to being at risk of choking. The person had made staff aware they wanted a 'normal' diet so the service had made a referral to the speech and language team (SALT). A speech and language therapist had visited the service and explained to the person the risks posed to them from a normal diet, for example aspiration. The person accepted the risk and so the SALT worked with the service to devise a menu for the person to follow. For example, using mincemeat and adding gravy to soften food. This shows the service was responsive to this persons wishes as well as ensuring their needs were being met.

The service employed an activities coordinator who was also qualified to provide care and support. They

provided activities to all people living at Polefield nursing home and used the lounge on the residential unit. We saw them asking people on the nursing unit, if they wanted to attend. We spoke with the activities coordinator, who was relatively new in post. Who explained that they tried to encourage people to join in activities, especially if it's an activity they know the person normally enjoys. We saw activity plans in place, incorporating games, events and exercises for people including bingo, dominoes, sing-alongs and quizzes. We also saw there were days allocated for one to one time to spend with those who were not able to join in group activities. We saw the activities staff member kept a record of the time spent with particular people.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found a number of concerns in relation to this service which was reflected in their last report. By law the service needed to display their rating from this report. On arrival at this inspection we noted that the rating was not being displayed. At lunchtime we noted that a copy of the rating had been printed off and stuck to the wall behind a hoist.

Failing to display the rating is a breach of Regulation 20A (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The action plan submitted by the provider after the last inspection detailed the actions they were going to take to meet the Regulations. We saw that some of these actions had been completed, for example, radiator covers had been fitted and the external waste area was now secure and tidy. However other areas of the action plan had either not been completed in the timescales given by the provider. For example, ensuring staff were appropriately trained. Or had not been included in the action plan for example policies and procedures. At this inspection we have identified five breaches of regulations, four of which had previously been identified when we last inspected and additionally a breach for failing to display the rating of the service.

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

At our previous inspection the owner of Polefield Nursing home was going to apply to register with the Care Quality Commission as registered manager. At this inspection we found that the application had not yet been completed. The service had not had a manager since March 2016. Staff had previously felt unsupported but now felt things were improving and they were receiving supervisions every two to three months. The owner was now working as the manager so the service now had some leadership and a relative commented, "There has been a real improvement. [Manager] got staff on-board now." Everyone we spoke with knew who the manager was and told us he was always around.

Despite the provider acting as the manager of Polefield nursing home, we found there were several areas which the service continued to be in breach of areas and issues we had previously raised, still had not been addressed. At the previous inspection we found that policies and procedures were out of date and not being followed by staff. At the time we raised this with the provider who told us they planned to purchase some new policies and staff would need to read them and sign to say they had read and understood them. At this inspection we found this still had not happened. When we spoke with the provider about this, we were told they were trying to update the policies but to date, had not done so.

At the previous inspection in April 2016, we found the service was not carrying out quality assurance checks on the service. At this inspection we looked at whether the service was now monitoring people's experiences through audits and reviews. We found the service was now carrying out audits in areas such as medication, falls monitoring and accidents and incidents as well as daily checklist on areas on areas such as: the waste

bin area, call buzzers and fire exits. However we found where the service had identified issues action had not been taken to prevent these issues from reoccurring. For example, where the service had identified staff were following poor practice by not signing or recording when people had refused or not taken their as prescribed medicines. The service had not taken sufficient action to prevent this from reoccurring and we found this poor practice continued. We discussed this with the provider who said, they couldn't tell us why it was still happening as they had spoken with the staff who it involved and things had changed. We also saw where daily checks should have been completed for areas such as fridge temperature as well as treatment room temperature, these had not always been recorded and we saw gaps in the record sheets. The provider was unable to tell us what actions they would take in future to prevent it from re-occurring.

Staff we spoke with confirmed that staff meetings were now being held. The last meeting had covered the CQC report and the on-going improvements made to the home. We asked staff if they had seen any changes since our last inspection. We were told by one staff member, "[The manager] has done a lot. It was very shabby," and "[The manager] hasn't finished yet. They're going round the bedrooms slowly." All the staff we spoke with liked working at Polefield nursing home and believed there was an open culture. Staff believed they could approach the manager for anything and he'd try and arrange it (within reason). One staff member told us, "[Manager] is hands on, it makes such a difference."

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We found the service was notifying us of all incidents as required.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failing to store cleaning products securely. Not ensuring that staff were completing accurate records of peoples medicine administration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure that all records were stored securely. The continued failure to monitor, assess and drive up improvements in the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure there were sufficient staff on duty. The failure to ensure all staff were appropriately trained to carry out the role safely.