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Polefield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Polefield Nursing Home on Tuesday 21 August 2018. We returned for a second day to complete the inspection on Friday 24 August 2018, however we announced this in advance.

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 situated over two floors and has a passenger lift between the upper and lower level. The home is set back from the main road, with level access grounds. There is a large garden area which people can access.

We last inspected Polefield Nursing home on 27 September 2017 where the home was rated as Good overall and for each key question, safe, effective, caring and responsive. The well-led key question was rated as Requires Improvement to ensure the improvements made were sustained.

At this inspection in August 2018, we found several areas had since declined and identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) relating to safe care and treatment, safeguarding people from abuse and improper treatment (two parts of this regulation), good governance (two parts of this regulation) and staffing. We have also made two recommendations relating to staff recruitment and handling complaints.

You can see what action we have asked the home to take at the end of this report.

We looked at how the service managed risk. Some people living at Polefield Nursing Home required the use of bedrails to help keep them safe whilst they were sleeping and prevent them from falling from bed and hurting themselves. However, we found appropriate risk assessments were not always in place to demonstrate how risks such as entrapment in the bedrails would be mitigated.

We looked at the systems in place to prevent pressure sores and keep people's skin safe. We saw equipment was used such as pressure relieving mattresses and cushions, however we saw one person's airflow mattress was not being maintained at the correct setting and in line with their body weight as required. This could have placed this person at risk of skin breakdown.

We looked at the systems in place to safeguard people from abuse and improper treatment. One person living at the home told us they had been roughly handled by a member of staff and that the registered manager was aware of this incident. This had not been reported as a safeguarding concern however and we requested this was done during the inspection.

Accidents and incidents were monitored and body maps completed to identify any injuries. One person had been found with some bruising to their stomach area when they moved into the home, however information had not been accurately recorded about what had happened to the person and if further investigation was

required.

Medication was given to people safely, however we found a number of discrepancies with running totals, particularly on the upstairs residential unit, where staff were not accurately recording the correct number of tablets people had left once they had been administered. Cream charts were being completed on the nursing unit to show they were being applied as prescribed, however cream charts were not being completed on the residential unit.

The home was generally clean and tidy, however we noted some carpets and chairs, particularly on the residential unit were stained and would benefit from being replaced.

Effective systems were not in place regarding deprivation of liberty safeguards (DoLS) and the mental capacity act (MCA). Applications for DoLS were not always made in a timely way and mental capacity assessments were not always carried out when concerns were identified regarding people's decision-making abilities.

Not all staff received timely supervision and appraisal to support them in their role effectively.

We looked at how people were supported to maintain good nutrition and hydration. People's body weight was kept under review, although where there was a requirement to weigh people weekly, this was not always being recorded as required, particularly on the residential unit.

Accurate and contemporaneous records were not always being maintained regarding people's personal care and fluid intake.

Staff were recruited safely, with appropriate checks carried out before staff commenced employment. However, we recommend the home keeps an accurate record of all interviews that are held to demonstrate the questions asked and responses received as this was not being done consistently.

We looked at how complaints were handled and saw they had been responded to appropriately. However we recommend all verbal complaints and concerns raised are clearly documented on the complaints log, in line with the home's complaints policy and procedure.

At the time of the inspection, the home were actively trying to recruit an activities coordinator and some of the feedback we received from people was that there was not enough for people to do during the day.

Each person living at the home had their own care plan and this provided a clear overview about the care they needed to receive. Life histories, which provided an overview of people's likes, dislikes and preferences had not been completed for each person however and this meant person centred information about people's preferences was not always available for staff.

A range of policies and procedures were in place, however these were due for renewal in January 2018 and needed to be updated to show they had been checked and that the information was still current.

We found improvements were required to overall governance and quality monitoring systems. This was because concerns identified during this inspection were not always being identified through the home's own auditing systems.

People told us they felt safe living at Polefield Nursing Home. Staff were trained in safeguarding and

demonstrated a good understanding of the process to follow regarding suspected abuse.

We found there were enough staff to care for people safely.

Staff received sufficient training and induction to support them in their role.

People received enough to eat and drink and we saw timely referrals were made to other health care professionals when there were concerns about people's nutritional status such as speech and language therapy (SALT) and the dietician service.

People received food and drink of the correct consistency which protected them from the risk of choking.

We received positive comments from people spoken with about the care provided at the home. People told us they felt treated with dignity and respect by staff.

Appropriate systems were in place to ensure people's cultural beliefs were upheld and respected by staff.

Appropriate systems were in place to seek feedback from staff, relatives and people living at the home, through the use of satisfaction surveys and both residents and staff meetings.

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

Not all aspects of the service were safe.

Allegations of abuse were not always reported to the local authority for further investigation.

Appropriate risk assessments were not always in place for the use of bed rails.

One person living at the home was placed at risk of skin break down because their pressure relieving mattress was on the wrong setting and not in line with their body weight.

Accurate records were not always maintained regarding people's medication and accidents/incidents.

We have made a recommendation regarding the recording of staff interviews during the recruitment process.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Appropriate systems were not in place to ensure MCA assessments were undertaken and that DoLS applications were made in a timely manner.

Staff did not receive regular supervision and appraisal.

Accurate records were not always maintained regarding people's weight and fluid intake.

Is the service caring?

Good

The service was caring.

We received positive comments from people about the care provided.

People were treated with dignity and respect.

People's cultural beliefs were respected.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Accurate and contemporaneous records were not being maintained for each person living at the home.

The home did not have an activity coordinator at the time of the inspection and some of the feedback we received was that there was not enough for people to do.

We have made a recommendation regarding the recording of verbal complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The service has a poor inspection history and improvements found at our last visit to the home in September 2017 had not been sustained.

Quality assurance systems were not effective in identifying the concerns found during this inspection.

Policies and procedures needed to be updated to demonstrate they were being regularly reviewed.

Staff meetings took place so that staff could discuss their work, however actions from these meetings were not always followed through.

Polefield Nursing Home

Detailed findings

Background to this inspection

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

We carried out an unannounced inspection of Polefield Nursing Home on Tuesday 21 August 2018. We returned for a second day to complete the inspection on Friday 24 August 2018, however announced this in advance. The inspection team consisted of two adult social care inspectors from the CQC (Care Quality Commission) and an expert by experience on the first day of the inspection. An expert by experience is someone who has personal experience of caring for people, similar to those living at Polefield Nursing Home. The second day of the inspection was undertaken by one adult social care inspector only.

As part of our inspection planning we reviewed all the information we held about the home. This included previous inspection reports and any notifications sent to us by the home including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection.

We had not asked the provider to complete a Provider Information Return (PIR) as part of this inspection. 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.

At the time of the inspection there were 32 people living at the home. During the day we spoke with both partners (one of whom is the registered manager), the deputy manager, eight people who lived at the home, five visiting relatives, one nurse and five care assistants from both the day and night shift. As part of the inspection, we looked around the building and viewed records relating to the running of the home and the care of people who lived there. This included medication administration records (MAR), nine care plans and six staff personnel files.

We spoke with people in communal areas of the home and in their bedrooms if this was where people chose to spend their time. Throughout the day we observed how staff cared for and supported people living at the home and observed lunch being served on both the residential and nursing units to see if people's

nutritional needs were being met.

Requires Improvement

Is the service safe?

Our findings

We looked at how risk was managed to ensure people were not being placed at harm. We saw people had individual risk assessments in their care plans which covered areas such as falls, skin integrity and moving and handling. Where people were identified as being at risk, there was guidance for staff to follow within the corresponding section of their care plan about how risks could be mitigated.

We noted a number of people living at the home required the use of bed rails to help keep them safe whilst in bed and prevent them falling and hurting themselves. Despite this, appropriate risk assessments had not been completed for two people on the downstairs nursing unit to demonstrate how risks such as entrapment would be prevented. The registered manager informed us these had been completed following our inspection.

We looked at the systems in place to keep people's skin safe and reduce the risk of developing pressure sores. People living at the home had skin integrity care plans and waterlow risk assessment in place which provided an overview of the care they needed to receive. We saw equipment such as pressure relieving cushions and airflow mattresses were used to help keep people's skin safe when they were sitting and lying down for long periods. Specialist advice was sought where necessary and referrals made to services such as tissue viability nurses (TVN) as required.

We observed one person in their bedroom who was lying on an airflow mattress that needed to be set in line with their body weight to ensure it provided the correct level of pressure relief whilst the person was in bed. We noted the mattress was set to 140 kilograms, however when checking the person's weight records, we saw they only weighed approximately 48 kilograms. We raised this concern with the registered manager and were told new mattresses were in the process of replacing these mattresses with ones that automatically changed the setting in line with people's weight. They also altered the mattress to the correct setting. Daily records had also been completed by staff stating the mattress was set correctly. However this meant there was a risk the person could be exposed to skin break down.

Due to the concerns regarding pressure relieving equipment and bedrail risk assessments, this meant there had been a breach of regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) with regards to safe care and treatment. This was because the service were not assessing the risks to the health and safety of service users of receiving the care or treatment and were not doing all that is reasonably practicable to mitigate any such risks.

We looked at how accidents and incidents were monitored within the home. We saw a monthly log of incidents was maintained and captured details about any injuries suffered and recommendations to avoid similar incidents in the future. Body maps were also completed, which detailed the location on people's body where they had been injured.

We spoke with one relative during the inspection who told us a resident had been aggressive towards them when they had visited the home. Although this had been reported, an incident form had not been

completed to demonstrate how this needed to be monitored in the future. Another person had a body map in their care plan which showed they had been found with bruising to their stomach on admission. The registered manager said this was due to a condition they suffered from, however nothing had been recorded about this on the body map and if anything needed to be followed up. The registered manager contacted us after the inspection and said these had been updated to contain additional details.

We looked at how medication was handled to ensure people received their prescribed medication safely. We saw medicines were stored securely within locked trolleys and kept in a treatment room when not in use. Each person living at the home had a medication administration record (MAR) where staff signed when people had been given their medication. We found these were accurately completed and we did not find any missing signatures. Each MAR contained a photograph of the person and would reduce the risk of medicines being given to the wrong people. A medication fridge was used for any medicines that needed to be kept at certain temperatures and we saw staff maintained records to show that the temperature was checked each day and did not fall or rise to an unsafe level.

Some people required the use of PRN (when required) medicines and we saw protocols were in place to inform staff when these needed to be given and under what circumstances. One person required their medication to be given covertly (administered without a person's knowledge) and we saw this had been authorised by the person's GP for it to be done in this way. We observed several medication rounds during the inspection and saw people being asked if they would like to take their medication and were offered a glass of water to make it easier to swallow.

Some people living at the home needed creams to be applied by staff to help maintain good skin health. We found these were not always being recorded, particularly on the residential unit. This meant we could not be sure people always received their creams because of the records being maintained. Where medication was being given to people from a box as opposed to a blister pack, we found there were some discrepancies with the 'running totals' of tablets that should be left. We found the number of tablets left to be accurate, however accurate records were not being maintained.

We have addressed the recording concerns regarding accident and incident documentation and medication within the responsive section of this report.
We looked at the systems in place to safeguard people from abuse. We noted approximately 82% of staff had received safeguarding training and when spoken with, displayed a good understanding about safeguarding, the types of abuse that could occur and potential signs and symptoms of abuse to look for. A log of safeguarding concerns was maintained which had been sent to the local authority for further investigation.

The home had a policy and procedure in place which provided an overview of the process to follow if any abuse was identified. The policy referred to the fact that abuse could include pushing/pulling a person or handling them in a rough way. One person living at the home told us they felt a member of staff had been rough with them on one occasion and had pulled their arm, which the registered manager was aware of. We looked at the safeguarding log however and this incident was not documented. We asked if this had been treated as a safeguarding concern, however were told it hadn't been. We asked the registered manager to raise this as a safeguarding alert and were informed this had been done.

This meant there had been a breach of regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) with regards to safeguarding people from abuse and improper treatment. This was because systems and processes had not been operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

We looked at how staff were recruited to ensure this was done safely and reviewed six staff personnel files during the inspection. These contained application forms, references, photo identification (ID) and evidence disclosure barring service (DBS) checks had been carried out. The staff we spoke with confirmed these checks were carried out when they first commenced employment. We noted interview questions and responses were evident in two of the six files we looked at, however were not evident in the remaining four. We spoke with the deputy manager about this who told us they were not always recorded.

We recommend the home keeps an accurate record of each staff interview to demonstrate the questions asked and responses given by each applicant during the recruitment process.

We looked at how people were supported with their mobility to reduce the risk of falls. We saw people being assisted throughout the day as required and in line with their mobility care plan. For example, one person's care plan stated staff should make sure people knew where they were going when being supported to walk and we observed staff doing this when assisting a person to go to the toilet. The care plan also stated the environment needed to be free from clutter and we observed there were no trip hazards present whilst the person was being supported.

We looked at the staffing levels within the home to ensure there were enough staff to care for people safely. At the time of the inspection there were 32 people living at the home, with 17 people living on the residential unit and 15 on the nursing unit. Staffing levels for these numbers consisted of a nurse, two care assistants and a modern apprentice on the nursing unit and a senior carer and two care assistants on the residential unit. During the inspection we spent time in lounge areas and saw people being assisted in a timely way such as being taken to the toilet, assisted with their mobility and supported when in their bedroom. We observed staff being present in communal areas where people were seated and responded to call bells as quickly as they could when people were in their bedrooms.

We asked staff for their views and opinions of current staffing levels. One member of staff said, "It is a lot better downstairs now we have an additional member of staff who is the apprentice. That helps us out a lot and is an extra pair of hands. I would say they are sufficient for now." Another member of staff said, "We are fine and all the residents are okay from my point of view. The nurse helps us a lot downstairs which is good."

We looked at building maintenance records to check the building was being appropriately maintained. We saw documentation and certificates, which demonstrated that relevant checks had been carried out in respect of gas and electrical safety, risks associated with waterborne viruses and hot water temperature checks. We checked that upper floor windows were compliant with safety regulations and found appropriate window restrictors were in place. The lift had been serviced in June 2018, with some remedial work required which we saw had been addressed to ensure it was safe for people to use.

We looked at the systems in place regarding infection control. Overall we found the home to be clean and tidy, however noted several carpets and arms chairs on the residential unit were stained and would benefit from being replaced.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 if the home was working within the requirements of DoLS and the MCA. The home maintained a matrix regarding DoLS applications, detailing when they had been granted and were due to be followed up once they expired. However we identified several instances where DoLS applications were not always made in a timely manner. For example, a mental capacity assessment had been carried out for one person where it was determined the person lacked capacity to consent to the care and treatment they received and an application for DoLS had subsequently not been made.

In another person's mental capacity care plan, they had been assessed (for the past three months) as 'Being submissive and not able to make decisions. Others make decisions in my best interest'. Due to staff having concerns about this person's capacity, a mental capacity assessment had not been carried out and again, an application for DoLS had not been made. Neither of these people were listed on the DoLS matrix to be kept under review. When we spoke with staff about these people, they stated it would not be safe for them to leave the home safely due to the risks this would present and both people required the use of bed rails which would restrict their movements within the home.

This meant there had been a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) with regards to safeguarding people from abuse and improper treatment. This was because there was a risk people were being deprived of their liberty without lawful authority.

We looked at the training, supervision and appraisal staff received to support them in their role. Staff we spoke with told us they completed an induction when they first started working at the home and were introduced to people and shown around the building. This provided them with an overview of working in a care environment and how to deliver effective care and support. The induction provided staff with a detailed understanding in areas such as moving and handling, fire, food hygiene, health and safety, the call bell system, professional conduct, medication and training requirements. One member of staff said, "It gave me a good overview of the job and working at the home."

The home maintained a training matrix, which provided an overview of courses staff had completed. These included safeguarding, moving and handling, medication awareness, MCA/DoLS, dementia awareness and basic life support. Specific training was also provided for topics such as dysphagia and PEG for registered nurses. The staff spoken with during the inspection said enough training was available. One member of staff said, "I feel up to date with a lot of my training and have done a lot on the last 12 months. We do both face to

face and online training and I would say enough is provided for staff."

We checked to see if staff were receiving appropriate supervision and appraisal where they could discuss their work in a confidential setting, raise any concerns, discuss training and development opportunities and receive feedback about their performance. A supervision and appraisal matrix was maintained, consisting of 31 members of staff. However this showed 23 staff had not received a supervision in 2018. Staff spoken with during the inspection confirmed supervisions were not always held on a regular basis. We raised this with the registered manager who acknowledge these had fallen behind.

This meant there had been a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) with regards to staffing. This was because staff did not always receive appropriate supervision as is necessary to enable them to carry out the duties they are employed to perform.

We looked at how people were supported to maintain good nutrition and hydration. Each person living at the home had a nutrition care plan in place which provided an overview of the support they needed. Malnutrition universal screening tools (MUST) were completed and enabled staff to monitor people's nutritional status and determine if people were at risk. We noted that where people were scored at 2 or above on their MUST, appropriate referrals were then made to the dietician service. We saw one person had lost weight in May 2018 and following a referral to the dietician service had slowly gained approximately four kilograms.

Some people living at the home required the food to be prepared at a different consistency such as 'fork mashable' where staff mashed the food up in advance, making it safer to swallow. This had been advised by the speech and language therapy (SALT) service following assessment. Certain people also needed their drinks to be made at thicker consistencies and we observed staff preparing people's food and drink in this way so that they were not being placed at risk of choking.

We observed people being supported to eat and drink at meal times on both the residential and nursing unit. People were asked if they would like to go into the dining room for lunch, or stay in the lounge area.

The food looked appetizing, with favourable portion sizes offered to people. Tables in the dining room were not laid however and contained no cloths, napkins, decorations or condiments. Staff wore aprons and gloves and people were offered aprons to protect their clothing. A choice of food was available such as cereals, white or brown toast and porridge for breakfast. Some people had egg or beans on toast when they asked for it.

People's body weight was kept under review, however we noted several discrepancies with the recording of people's weight. For instance, where some people needed to be weighed weekly, this was being done monthly. This was predominantly on the residential unit.

We looked a people's fluid charts to ensure people were receiving sufficient hydration. We observed drinks being served in-between meals, with some people asking for hot chocolate which was provided for them. Records of what people had drunk were maintained, however we noted one person's fluid intake was much lower than the recommended target in their care plan. For instance, the care plan indicated staff should encourage this person to consume approximately 1600 millilitres of fluid each day, however we noted that on seven days in August 2018 that this target had not been reached, with what was offered and refused not always recorded. These had also not been signed off by the nurse on the unit to establish if the amount was sufficient and if any action needed to be taken.

We found these to recording concerns and that the home took appropriate action when people were identified as losing weight and observed drinks being served to people throughout the day. As mentioned in the safe domain, we will address the recording concern relating to the recording of people's weights and fluid intake within the responsive section of this report.

We looked at the suitability of the premises. We noted there was dementia signage on doors to the lounge, toilets and dining room. Some bedroom doors had large numbers and the name of person so that their room could be located easier should they become confused. The residential unit is accessible via stairs and a passenger lift, with keypads used on locked doors to areas such as the kitchen, medication treatment room and exits/entrances.

We saw people were supported to maintain good health, with a record of any professional involvement held in their care plan. People were referred in a timely manner to other health professionals such as TVN (tissue viability nurses), SALT (speech and language therapy) and the dietician service. People were supported to attend any appointments by staff and we observed a person being assisted to the hospital during the inspection.

We saw people's needs were assessed when they first moved in to Polefield Nursing Home. This would ensure staff had a clear understanding about the care and support people required.

Good

Is the service caring?

Our findings

We asked people living at Polefield Nursing Home and their visiting relatives for their views and opinions of the care they received. One person said, "I think it's brilliant." Another person said, "I'm happy with it." A visiting relative added, "We've been happy with her care."

We asked people about the staff working at the home and if they were kind and caring towards people. One person said, "Brilliant, I've not got a wrong word to say about them. They're good, really kind." Another person said, "I get on with all of them all, they're kind." A relative added, "They are very good. Even the cleaners take an interest in him and see how he is."

During the inspection we observed caring and pleasant interactions between staff and people who lived at the home. For example, we observed several people returning to the lounge area after being assisted to have a shower and staff commented how clean and smart they looked. Staff took the time to see what people wanted to do such as asking people what they would like to wear, where they would like to sit and if people would like to get up from their chair. We also saw staff were patient with people during tasks such as assisting with mobility and informed people what they needed to do to ensure any transfers were done safely and in a dignified manner.

People living at the home told us they felt treated with dignity and respect by staff. During the inspection we observed staff knocking on people's doors before entry and assisting people away from communal areas to help them with their personal care. We observed staff closing doors behind them to protect people's privacy when assisting them with their personal care and people said staff never made them feel uncomfortable or embarrassed.

During the inspection we observed promoting people's independence and allowing people to do things for themselves if they were able to. For example, allowing people to walk around the home on their own whilst using their zimmer frame to assist with their mobility. We also saw staff bring people food and drink from the kitchen but then allowing people to eat on their own.

We looked at the systems in place to ensure people were able to communicate effectively. We saw people living at the home had specific communication care plans in place which took into account people's language, preferred communication methods and any equipment required such as glasses or hearing aids. Where people required the use of this equipment, we saw it was available to them during the inspection. In one person's care plan is described how staff should speak to them at eye level and we observed staff crouching down next to them to they could see them whilst they were speaking.

We looked at how the service ensured people's equality, diversity and human rights needs were met. We noted that where there was a requirement, people had appropriate care plans in place to inform staff about how these requirements needed to be respected. For example, one person chose not to eat beef and liked to wear different style clothing as part of their religion and beliefs and we saw this being respected during the inspection. The person's first language was not English and therefore interpreter services were available,

however several staff within the home also spoke their language and were available to assist as required.

The home maintained a list of compliments where people had express their satisfaction with the level of care provided at the home. We read a sample of these during the inspection, some of which read; 'Thank you very much for all of the care and attention you gave to our wife/mum during her time at Polefield Nursing Home' and 'To all the staff at Polefield Nursing Home, thank you for everything you did for mum' and 'I am sending this thank you note to let you know how much your thoughtfulness is appreciated. Thank you very much for helping my dad'.

Requires Improvement

Is the service responsive?

Our findings

As mentioned within the safe and effective sections of this report, we identified some concerns with record keeping regarding accident/incident forms, cream charts, carry forward totals on MAR sheets, weight records on the residential unit and fluid intake sheets. We found these were recording issues rather than people being placed at risk of harm.

In addition to this, we also identified further recording concerns relating to people's personal care charts. These documents detailed when people had received a bath/shower, had their nails cut/cleaned and had been assisted with their oral hygiene by staff. We found gaps in these records relating to four people on the residential unit for the month of August 2018.

Each person living at the home had their own care plan, covering areas such as personal care/hygiene, eating and drinking, communication, skin integrity, mobility and continence. We noted these were completed with good detail and provided a clear overview of the care staff needed to deliver. Assessments of people's care needs were undertaken when people first moved into the service and this allowed for people's care plans to be created. Care plans were up to date and were reviewed each month to ensure the information was still accurate.

Some of the care plans we looked at contained information about people's 'Life history' and took into account areas such as previous employment, hobbies and interests and their family background. These had not been completed for each person however and we noted they were absent from four people's care plans on the nursing unit. This meant staff did not have access to information about things people liked/disliked.

These recording concerns meant there had been a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because there had been a failure to maintain an accurate, complete and contemporaneous record in respect of each service user.

We looked at the activities available within the home and asked people if they felt there was enough for them to do. Everyone said there was a lack of activities, with people on both units telling us they often felt bored. One person said, "There is definitely a lack of activities." Another person said, "If there would be one thing they could do better then it would be more activities."

At our last inspection, the home had an activities coordinator in post and the feedback we received about the activities available had been positive. The activity coordinator had since left their post however and care staff were responsible for facilitating any activities. At the time of the inspection, the home were looking to recruit someone new to the post. We did however see some people engaged in one to one activities such as playing the board game connect four, completing jigsaws and using colouring in books, however people said these activities weren't always facilitated each day.

We looked at how complaints were handled. A complaints log was maintained and this provided details

about the nature of the complaint and any actions taken. There was a policy and procedure in place and this clearly explained the process people living at the home and their relatives could follow if they were unhappy with any aspect of the service. The policy also made reference to the fact that all verbal complaints must be recorded in the complaints book, with information about how they specific issue would be addressed. The majority of people we spoke with said that when they had made a complaint it had been resolved, however one relative told us they had made a verbal complaint about the behaviour of one resident and this had not been logged to detail any actions that had been taken.

We recommend the home maintain a log of all verbal complaints made, in line with the policy and procedure.

Relationships were encouraged to be maintained and we saw families and friends came to see people throughout the day, with no restrictions on visiting times.

We looked at the systems in place to seek and respond to feedback from people living at the home, relatives and visiting health care professionals. We noted the home had sent surveys to people in July 2018, asking for their views and opinions about feeling welcome, if people were safe and not being ill-treated, acting on recommendations, if the care was of a good standard and if abuse had ever taken place. Residents meetings also took place and we reviewed the minutes of the last meeting in March 2018 where topics of discussion had included activities, menus and any additional things people wanted to raise. We saw the home had been responsive to things people raised. For example, one person had requested their wardrobe to be fixed and we saw this had since been repaired.

We looked at the arrangement in place regarding end of life care. Where required, we saw people had end of life care plans in place and this took into account people's requirements approaching the end of their life and how they would like their care to be delivered. For example, being treated in a respectful manner, with dignity and respect, allowing the family to be involved and ensuring any end of life medicines, such as for pain relief were given. We found pain relief medicines were being administered as required, such as oxycodone and were documented on MAR sheets.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were completed and had enabled people and their families to express their wishes in this area, should they need to be resuscitated. Family members were welcome at any time during periods of end of life care and were given somewhere to sleep overnight if needed. A visiting professional said to us, "End of life care is really good''. They are very prompt at referring people, particularly if there is pressure damage."

Inadequate

Is the service well-led?

Our findings

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

Polefield Nursing Home is owned by Mr Mohedeen Assrafally & Mrs Bibi Toridah Assrafally, a partnership first registered with CQC in November 2015 and one of the provider partners was also the registered manager.

The home has previously had a poor inspection history and has been rated Inadequate overall on two occasions. We had also take enforcement action regarding the home's CQC registration and added a condition to the providers registration that they could not admit any new residents into the home without CQCs authorisation.

At our last inspection in September 2017, this key question was rated as Requires Improvement to ensure that improvements made during this inspection were sustained over a period of time. However we found those improvements had not been sustained and found service delivery had declined in a number of areas.

We looked at the systems in place to monitor the quality of service being provided to ensure good governance. A number of audits were in place within the home and covered areas such as water, complaints, fire safety, health and safety, medication and building safety. These were completed each month and had been done up until July 2018. Some of the audits were not always being done as frequently and did not always pick up on the concerns we had found during the inspection. For example, an environment audit had been completed in July 2018 stating lounge carpets and chairs were in good condition, yet we had found them to be stained and in need of replacing. Care plan audits had also not been undertaken since 2017. The registered manager said these had been the responsibility of a previous member of staff, however they had since left.

Team meetings took place and presented staff with the opportunity to discuss their work and raise any concerns about practice within the home. We noted the meeting minutes from February 2018 had highlighted a concern regarding cream charts not being completed and stated a weekly audit would be done. The last meeting in July 2018 had also raised a concern about personal care charts not being completed. We found these issues were still of concern at the time of the inspection.

We found further improvements were needed to overall quality assurance to ensure they identified the concerns from this inspection. For example bed rail risk assessments, pressure relieving mattresses not on the correct setting, DoLS applications not being made, supervision and appraisal not taking place on a frequent basis and life histories missing from people's care plans.

These concerns meant there had been a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because there had

been a failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

A range of policies and procedures were in place and covered areas such as complaints, safeguarding, whistleblowing, health and safety and infection control. These were due to be reviewed in January 2018 however this had been done at the time of the inspection. The manager confirmed these would be reviewed following the inspection.

Confidential information was stored securely. This included staff personnel files, care plans and daily records being locked in metal filing cabinets which only staff had access to. During the inspection we observed that these records were never left unattended and were stored away once they had been looked at. This would ensure people's personal information remained safe.

The provider was aware of notification requirements and the manager had informed CQC of significant events in a timely way. This meant we could respond accordingly to any incidents which took place.

We saw the service worked in partnership with other agencies as required. For instance we saw other health professionals services such as opticians, podiatrists, dieticians and speech and language therapists all worked closely with the home to achieve better outcomes for people and their families.

As of April 2015, it is now a requirement to display the ratings from the previous inspection at the home and on any corresponding websites. We saw the ratings from the last inspection were clearly displayed near the front entrance of the home. The ratings were also displayed on the homes website. This meant people living at home, visitors and health care professionals knew about the level of care provided at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure people received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate systems were not in place to ensure people were safeguarded from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Appropriate systems were not in place to ensure staff received appropriate supervision as part of their role.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Appropriate systems were not in place to ensure good governance.

The enforcement action we took:

We issued a warning notice regarding this regulation