Fieldhouse Ltd

Church Farm at Field House

Inspection report

11 Main Road
Radcliffe-on-Trent
Nottingham
Nottinghamshire
NG12 2FD

Tel: 01159335811
Website: www.fieldhousenursinghome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 August 2017 and the first day was unannounced.

Church Farm at Field House was last inspected in November 2014 and was rated Good.

The provider is registered to provide accommodation for up to 50 older people over two floors. There were 47 people using the service at the time of our inspection.

A registered manager was in post but was on leave at the time of our inspection visit. 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.

Risks were not always managed so that people were protected from avoidable harm. Sufficient numbers of staff were not deployed to meet people's needs at all times. Staff did not always follow safe medicines management and infection control practices.

People's rights were not fully protected under the Mental Capacity Act 2005.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. As a result the provider and registered manager were not fully meeting their regulatory requirements.

Staff received induction and training but supervision and appraisal levels needed improvement. People told us they received sufficient to eat and drink but the mealtime experience could be improved in one dining area. Adaptations could be made to the design of the home to better support people living with dementia.

People did not always receive personalised care that was responsive to their needs. People experienced varying levels of support to maintain interests and hobbies. Care records did not contain information to always support staff to meet people's individual needs.

Staff understood their duty to protect people from the risk of abuse and knew how to report any concerns. Staff were recruited through safe recruitment practices.

External professionals were involved in people's care as appropriate.

There was limited evidence that people were involved in decisions about their care. However, some relatives were involved in decisions about their family member's care.

People did not always receive care that respected their privacy and dignity.

Staff were kind and knew people well. Staff effectively responded to people showing signs of distress. Advocacy information was made available to people. People's independence was promoted and they could receive visitors without unnecessary restriction.

A complaints process was in place and staff knew how to respond to complaints. Complaints were generally responded to appropriately.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising concerns with the management team and appropriate action would be taken.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not always managed so that people were protected from avoidable harm.

Sufficient numbers of staff were not deployed to meet people's needs at all times.

Staff did not always follow safe medicines management and infection control practices.

Staff understood their duty to protect people from the risk of abuse and knew how to report any concerns. Staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005.

Staff received induction and training but supervision and appraisal levels needed improvement.

People told us they received sufficient to eat and drink but the mealtime experience could be improved in one dining area.

Adaptations could be made to the design of the home to better support people living with dementia.

External professionals were involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There was limited evidence that people were involved in decisions about their care. However, some relatives were involved in decisions about their family member's care.

People did not always receive care that respected their privacy and dignity.

Staff were kind and knew people well. Staff effectively responded to people showing signs of distress. Advocacy information was made available to people. People's independence was promoted and they could receive visitors without unnecessary restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs.

People experienced varying levels of support to maintain interests and hobbies.

Care records did not contain information to always support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints. Complaints were generally responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising concerns with the management team and appropriate action would be taken.

Church Farm at Field House

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 7 and 8 August 2017 and the first day was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home. This information was used to help us to plan our inspection.

During the inspection we observed care and spoke with 10 people who used the service, seven visiting families, a visiting healthcare professional, a visiting training assessor, the maintenance person, two support staff, the cook, two housekeepers, four care staff, a nurse, the deputy manager, the training manager, the head of operations and the nominated individual of the provider. We looked at the relevant parts of the care records of 15 people who used the service, three staff files and other records relating to the management of the home.

The registered manager sent us further information following their return from leave which we have considered and included, where appropriate, in this report.

Requires Improvement

Is the service safe?

Our findings

Individual risk assessments were completed for risks such as falls, nutrition, pressure ulcers and moving and handling. Nutritional risk assessments were completed at least monthly; however, other risk assessments were not always reviewed regularly. For example, a person at high risk of developing pressure ulcers had a risk assessment dated March 2017 but it had not been reviewed since. Another person had a pressure ulcer risk assessment in May 2017 but not reviewed after this. This meant that there was a greater risk that risk assessments were not up to date and actions had not been identified to minimise the risk of people suffering avoidable harm.

Two people we spoke with voiced concern over the frequency of their repositioning by staff. A person said, "They're supposed to turn me regularly but they're busy often so I'm uncomfy and my feet get sore if down." Another person said, "I'm turned two hourly supposedly. I lose count." Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. However, records were not always fully completed to show that people received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans.

We saw completed documentation relating to accidents and incidents and it was clear what actions had been taken to minimise the risk of them happening again. However, no analysis of falls across the home was taking place to identify themes and to identify any actions that could be taken to minimise the risk of falls across the home.

We saw that checks of the equipment and premises were taking place. However, we saw that parts of the premises and environment were not safe and staff were not always following safe working practices. Restrictors were not in place for all windows where required, potentially harmful substances were left unattended and bedside protectors were not always in place when bedrails were being used. This put people at risk of avoidable harm.

People did not raise any concerns about the cleanliness of the home. A person said, "It's very clean here." During our inspection we looked at some bedrooms, toilets, bathrooms and communal areas and found that the environment was generally clean, however, staff did not always follow safe infection control practices regarding the storage and cleanliness of equipment and preparation of food which could put people at the risk of infection.

Most people we spoke with told us that their medication was supervised and they received their medicines on time. However, two people we spoke with told us that staff often left their medication with them to take by themselves. A person said, "I get [medicines] on time. I have a lot of painkillers and they wait with me." However, another person said, "They leave them with me and let me have them when I'm ready." We observed that this person had an empty medicines pot on their bedroom table. This person's care plan stated that they should be supervised when taking their medicines to ensure they took them. This meant that staff had not effectively supervised this person to ensure they took their medicines. When we observed

the administration of medicines we saw staff made the necessary checks before administering medicines and stayed with people until they had taken their medicines.

Medicines administration records (MARs) mostly had a photograph of the person to aid identification and a record of any allergies. The deputy manager told us there were a few photographs missing as they had not yet been uploaded onto the new electronic system. There was no information about how the person liked to take their medicines.

Records indicated that medicines were administered consistently and we did not find any evidence of gaps in administration which were not explained. However, we saw one medicine was prescribed to be given regularly and staff at times had recorded it was not needed. This medicine is one which is frequently prescribed to be given only as required, however, it should be given as prescribed and the GP asked to review the prescription if it is sometimes not needed.

Protocols were not in place to provide the additional information need to ensure medicines, prescribed to be given only as required, were given consistently. Staff we spoke with were unaware of the need for these protocols. We saw that in some cases there was some limited additional information on the MAR about the reason for prescribing these medicines but this was incomplete. Liquid medicines were not always dated when opened which meant that there was a greater risk that they would be used after their effective date.

Medicines were stored in locked trolleys and cupboards within locked rooms. The temperature of the refrigerator and the rooms used to store medicines were recorded daily. The medicines room on the upper floor had an air conditioning unit and the temperatures were within acceptable limits, however, the temperature of the medicines room on the ground floor was above the recommended limit on two occasions within the past week. Staff told us this had been reported to the provider. The refrigerator was new; however, we saw the maximum temperature was recorded as 12c on several consecutive days. This is above the recommended limit. We asked a member of staff about how they reset the maximum/minimum readings, however, they were unclear about this and how the readings were gained. This meant that there was a greater risk that medicines were stored at a temperature that would affect their effectiveness.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Processes were in place for the timely ordering and supply of medicines. This was completed through the electronic medicines management system. Staff told us their training in medicines administration was checked when they started at the service and they said they had had their competency checked within the last few months. They told us they had been provided with training on the use of the new electronic medicines prescribing system.

Sufficient numbers of staff were not effectively deployed to meet people's needs at all times. Most people we spoke with felt that staffing levels were an issue, with staff frequently appearing rushed and task-led and assistance not always being given in a timely manner. A person said, "No, there's not enough [staff] at all. It's the waiting." Another person said, "[Staff] get a bit impatient. They're very rushed." A third person said, "Staffing is a difficult problem for them. They seem so busy." A visitor said, "There are sometimes staffing issues." However, a visiting professional told us that staff were always around.

People we spoke with told us that although call bells were sometimes responded to quickly, at other times they experienced long waits, with staff also not always returning as promised. A person said, "If I press the red one, they all come very quickly. Then they tell me to press the normal one." Another person said,

"Sometimes they're quick or it can be a long while. They stop my bell and tell me they'll be back but it can be another half hour or more. So I ring again but they don't come." A third person said, "They usually come okay or it may be an extra-long wait. I need it for the toilet so hang on. I've not had an accident as yet." A fourth person said, "They ignore me. They don't come, even when you're yelling like crazy. 30 minutes is a long time when you can't breathe properly when you're squashed in bed. It can be an hour to wait for them." Another person said, "It may be two minutes or half an hour or more. They don't always return when they say they will." A visitor told us that there were times where their family member had waited up to 20 minutes to be taken to the toilet. We observed that staff did not always respond to people promptly and call bells were not always responded to within a reasonable time. This meant people did not always receive care that was responsive to their needs.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member said they felt there were generally enough staff rostered on duty, however, they said, "It can be difficult when staff call in sick." They told us sickness absence was an issue, however, sickness was, "being tackled." Another staff member said, "People are safe but staff just don't have the time [to spend quality time with people]." We saw that the minutes from a staff meeting in July 2017 stated, "More staff required and [senior care staff] particularly needed." However, all care staff we spoke with felt that there were sufficient staff to meet people's needs.

A staffing tool was not being used to inform decisions about staffing levels. We were told that work was just starting to take place in this area. However, staff told us that people's dependency levels were considered when allocating staff.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People we spoke with told us they felt safe living in the home. A person said, "I feel very safe. Everybody keeps us safe." A visitor said, "I feel [my family member]'s kept safe and sound."

Staff were aware of safeguarding procedures and the signs of potential abuse. They knew what action to take if they suspected abuse. A staff member told us they were aware they could refer any concerns to the local authority if necessary and told us the contact number was displayed in the staff room. A safeguarding policy was in place and information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. This ensured people were kept safe from the risks associated with unsafe care.

People told us they were not unnecessarily restricted. The majority of people we spoke with told us that they chose to stay in their room for much of the day; although several others told us they had freedom to go where they wished in the building or be accompanied into the local town. A person said, "I can go anywhere I like. I pop into the office to say hello. I have to have someone with me if I go into town though." This meant that people were kept safe but not unnecessarily restricted by staff.

Before our inspection visit we were notified of an incident where a person had fallen while being moved with a hoist and suffered an injury. This incident is being investigated by the local authority and we have not received an outcome of their investigation at the time of this report. When we receive that outcome, we will consider whether we need to take any further action in relation to that incident. During our inspection we

checked to ensure that people were moved safely by staff using equipment.

People told us that they had the equipment they needed and that staff supported them to move competently. A person said, "They hoist me and that's very good by the [staff]." Another person said, "They've hoisted me a couple of times already and explain it. It's been okay so far." We saw that hoists and slings were checked regularly to ensure they were safe to use. We saw staff assisting people to move safely and encouraging them to use their walking aids as required. This meant that people were assisted to move safely by staff.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place and available for staff to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

Requires Improvement

Is the service effective?

Our findings

The provider was not working in accordance with the Mental Capacity Act 2005 at all times. People told us that staff did not always ask consent when rushed. One person said, "They always ask if I mind what they want to do." Another person said, "Mostly they ask first and tell me what's happening." However a third person said, "They're not always got time for the niceties unfortunately." We saw that staff generally asked permission before assisting people and gave them choices. However, this did not always take place at mealtimes where clothing protectors were put on people without giving the person the opportunity to say whether or not they wanted to wear a clothing protector.

Most people we spoke with told us that they chose their bedtimes, clothing and made day to day decisions. However, one person told us that staff put her to bed at 6pm. A person said, "I don't like them telling us to do things, like when to go to bed; so they ask me instead. I let them choose my clothing though." Another person said, "I tell them I'm up 'til 10pm then ring to go to bed. They let me choose what I'm wearing each day." However, a third person said, "They tell me I'm going to bed early at 6pm. I say I don't want to and they laugh and we still go to bed. They turn my tv and lights off." We looked at this person's care records which showed that she did go to bed around 6pm at times. We raised this management who agreed to look into the issue.

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 whether the service was working within the principles of the MCA.

We did not see any evidence of mental capacity assessments and best interest decisions in people's care records when they were unable to make some decisions for themselves. We were also told that a person had consented to the use of bedrails but could not see any evidence of this in their care records. We checked an authorised DoLS which had a condition in place. Staff were not aware of the condition and we saw that the authorisation had expired. This meant that staff had not taken appropriate steps to ensure the person's rights were protected in this area.

We spoke with a member of staff about the action they took when a person could not make decisions for themselves. They said they would assist the person as much as possible to make the decision and speak with the family. They did not mention assessing the person's capacity to make the decision and when we asked them about this they told us that a capacity assessment was completed when the person was admitted. They did not mention best interest decision making. The provider had identified that assessments

of capacity were taking place only on admission and decision-specific assessments were not taking place. They had recently introduced new documentation to support staff to carry out these assessments in the future.

This meant that people's rights were not being protected when they lacked capacity to make decisions. These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained some guidance for staff on how to effectively support people at times of high anxiety; however, they could be improved to provide guidance for staff on a more personalised approach to supporting people when in distress. However, staff were able to explain how they supported people with periods of anxiety and generally responded well to people in distress.

We looked at the care records for people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. We saw that not all DNACPR forms had been fully completed. This had not been identified by the service. Management agreed to contact the relevant healthcare professionals to ensure the forms were reviewed and fully completed.

People felt permanent staff were competent in their role but agency staff were less so. A person said, "I know [staff] all by name. They're very good with me." Another person said, "The older [staff] know what they're doing. I don't like agency as they're a bit rough and have hurt me by mistake when moving me. I tell my daughter if it happens so she can take it up." This person was not able to tell us who these staff were for us to take further action in response to their comments. A third person said, "You can tell the agency staff don't know us as we have to explain things." A visiting professional told us that staff were experienced and competent. We observed that staff generally competently supported people throughout the inspection.

Staff told us they had received an induction which prepared them for their role and records confirmed this. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. Training records showed that most staff were up to date with their training which included equality and diversity training. We were given a copy of the provider's training programme which provided remaining staff with sufficient opportunities to update their training. This meant that staff were provided with training to support them to provide people with safe care.

Staff new to the care sector were working through Care Certificate workbooks to improve their skills and knowledge. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to.

Some staff could not recall receiving recent individual supervision or appraisal. We saw that staff received supervision as a group but few staff received one-to-one discussions where they discuss their performance and any learning or support needs. We were told that supervisions were not taking place as frequently as set out in the provider's policies and that appraisals were overdue. We were told that action was being taken to address this issue. This meant that staff were not fully supported to maintain and improve their skills in order to effectively meet people's needs.

Feedback on the food was fairly positive, with choices offered and alternatives available. Special diets were also catered for by the kitchen. A person said, "I enjoy the food a lot – it's superb. We get a choice and are well treated. They'll cook me something special if I prefer as I don't like processed meat." Another person said, "I don't rate it much. I'm vegetarian and get a choice. It comes hot enough. Sometimes I need help so will get staff sitting with me." A third person said, "The food is alright – some days better than others. I get

asked my choice though sometimes it's not very warm." A visitor said, "[My family member]'s got a big appetite and enjoys her meals."

We observed the lunchtime meal on both floors. On the ground floor, there was a menu on each table. Tables were set with place mats, cutlery, and serviettes. Staff provided people's meals in a timely way and were attentive to people's needs. A member of staff was allocated to oversee the meal and ensure people received the support and encouragement they needed. When a person did not make much progress with eating their meal a member of staff asked them if they would like them to help them. When people needed assistance, staff sat with them and we saw a member of staff watching a person closely for their reaction and non-verbal cues to ensure they responded to their wishes. The member of staff talked encouragingly to the person throughout. The food smelt appetising and people appeared to eat with enjoyment.

The mealtime experience could be improved on the first floor. People received assistance where required from staff and were given choices and alternatives offered where required. However, meals were not explained when served to people which included a pureed meal which had been blended together and served in a bowl. The kitchen/dining area was noisy with the clatter of food service, plates and cutlery being cleared, hot plate being cleared and staff communicating.

Nutritional risk assessments were completed and eating and drinking care plans were in place. They provided information about the amount of support the person required and any special diets such as modified texture foods. However, there was no information about people's food preferences. Records showed that people were weighed regularly and appropriate action taken if people's weights were of concern.

People told us that they had sufficient to drink. A person said, "We have plenty provided in the way of drinks. I'm never thirsty." Another person said, "I've got my water jug and get the tea trolley three times a day for my cups of tea. They leave me two at a time as I like my tea." We saw that people were offered drinks throughout the inspection.

People told us they were supported with their healthcare needs. A person said, "The local doctor comes in if they call. I've had the dentist and chiropodist here, plus I think the optician is about once a year. The [staff member] does my nails and I'll have hair trimmed downstairs." Another person said, "I have hospital checks for my eye and we have our own dentist we get taken to. The chiropodist here is about every 6 weeks." A visiting healthcare professional told us that staff asked for guidance if required and followed any advice given. Care records contained a record of the involvement of other professionals in people's care, such as the GP, a motor neurone disease nurse specialist and a dietitian.

People were generally happy with the premises and environment though one person would have like their bed tidied quicker and another person was disturbed by the noise of the call bell system. A person said, "It's not tidied enough. My bed stays unmade until late." Another person said, "It's the noise of the bell alarm going off all the time that disturbs me." However, a third person said, "It's spacious, and homely to me." Another person said, "I love my double windows and have lots of my own things."

We noticed that the alarm bell sound was intrusive near bedrooms and communal areas, and was more noticeable when ringing unanswered for five to ten minutes. We also saw that a lot of the beds remained unmade until early afternoon, even when a person had been sitting in their room during the day, having to look at a crumpled bed. We also two other examples where people's wellbeing could have been affected by their surroundings. We saw that a tap had been left dripping and the door closure mechanism battery needed replacing and was beeping while a person was lying in bed in their bedroom. We also observed a

staff member vacuuming around people's feet while they were sitting in the lounge, some of them with their eyes closed.

Adaptations could be made to the design of the home to better support people living with dementia. Not all bedrooms, bathrooms and toilets were clearly identified to support people to find their way around the home. We saw records had identified that a person had been unable to find a toilet and as a result went into another person's bedroom where an incident took place.

Requires Improvement

Is the service caring?

Our findings

People told us that mostly family had responsibility for managing their affairs. None of the people we spoke with could recall having seen a care plan or being asked for their views on updates. A person said, "My [family members] have got power of attorney for me and one does all my banking too. They keep an eye on things here." Another person said, "My [family member] asks to see my turn record. She often talks to the office to check on me." A third person said, "I've not seen my care plans. My [family member] does a lot of planning for me." A visitor told us that they had opportunity to feed their views into the care planning process.

We were sent copies of letters sent to relatives encouraging them to discuss their family member's care; however, we did not see any evidence of people or relative's involvement in the development and review of care plans. The electronic record care record system had the capacity to store information about each person's life history however; this section of the record had not always been completed for the records we reviewed.

A person told us they struggled to communicate with some care staff. They said, "Sometimes the [care staff] I can't make understand so it's pointless trying." A visiting training assessor told us that they were impressed with how staff met people's diverse communication needs. However, when people were unable to communicate easily, care plans did not always provide sufficient information about the gestures or body language people used to communicate with and how staff could better understand them.

People told us staff respected their privacy and maintained their dignity. A person said, "They'll always close the curtains and door for some privacy. They knock too and I say "Come in!" Another person said, "They usually knock even if the door's open." A third person said, "They will usually knock and wait. Door and curtain closed is the norm when they're in the room."

However, another person said, "There's no dignity here!" We saw that this person was sitting in their bed with the door open and could be clearly seen in a state of undress from the corridor. The person told us that they wanted the door left open and had removed the bedclothes themselves. We raised this with management who informed us that following the inspection and with the person's agreement, the person had moved to a bedroom in a more private part of the home. This enabled the person to keep their bedroom door open and protect their dignity.

Staff maintained people's dignity when they assisted them by ensuring they were appropriately covered during moving and handling. They knocked on doors before entering and used do not disturb signs on bedroom doors when they were providing personal care. However, we noticed that one toilet did not have a working lock which meant a greater risk that people's privacy would not be protected. We informed the management who told us that they would address this.

While staff spoke discreetly about people's care needs, we saw that confidential information was not always stored securely. We saw that care records were not stored securely upstairs. While they were stored in a

room with the door closed, they were stored on open shelves which were clearly visible from the outside and the door was unlocked with no staff in attendance. We informed the management who told us that they would address this.

People told us that although most staff were kind and caring, some found agency staff less friendly. A person said, "Mostly they're nice, especially the long stay staff. Agency are not so good." Another person said, "They're very kind and nice but so busy." A third person said, "Oh I feel happy and safe here. [Staff] are very kind and supportive." A visitor said, "I find them very caring with people."

People told us they were comfortable with staff and felt listened to. A person said, "I'm totally relaxed with them helping me." Another person said, "I'll always get an answer to my worries if I ask the [staff]." Staff chatted with people in a friendly manner and talked with them about their interests. They showed knowledge of people and said they liked to spend time with them whenever they could.

Staff effectively responded to people showing signs of distress offering them reassurance and kind words. We were also told that each month support was available to people, relatives and staff to discuss bereavement. Staff told this was an opportunity for people to discuss their feelings around death and bereavement in a supportive environment.

Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

People told us that they were encouraged to be independent if they were able and to ask for help if required. A person said, "I'm really encouraged to do what I want to keep active." Another person said, "Even though I'm one handed now, they let me help in my care." A third person said, "I manage what I can and they let me try." Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

People told us there was no restriction on when they could receive visitors. A person said, "They're not tied to set hours thankfully." A visitor said, "I come most days late morning and am made welcome." Staff told us people's relatives and friends were able to visit them without any unnecessary restriction.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback regarding whether people received care that was responsive and met their needs. Although some people felt their care was personalised and staff went the extra mile, we also heard some examples of care that was not responsive or personalised. We noticed a large number of people choosing to remain in their room and there was no evidence of quality time being spent by staff with people in their room.

A person said, "I joined [further education courses] and go to the monthly meeting in town. A staff member takes me, drops me off and fetches me after." However, another person said, "I have a bath twice a week but would prefer one daily. [Staff] know as I've mentioned it but say they don't have the time, so I don't ask now." A third person said, "I'd prefer to have a bath at night to relax me but [staff] only do mornings, they say." Another person told us they preferred female staff when receiving personal care but said, "I don't mind now as it can't be helped when they're short staffed." However, a visitor said that the care was so good in the home that, "It feels like I've got my Mum back now." Another visitor said, "Staff are wonderful and attend to all of [my family member]'s needs."

Records did not show that all people were receiving the regular support and care they needed. For example a person's care plan stated they had a twice daily wash and weekly bath, however, we saw the records indicated they had a bath once in the previous month and had had bed baths or washes on other days. Another person's records did not always contain information on each day showing that they had received support with their personal care. A third person's care plan stated they should be checked hourly at night as they could not use a call bell. Records indicated they were usually only checked once or twice during the night.

People experienced varying levels of support to maintain interests and hobbies. People gave mixed feedback on activity provision at the service. A person said, "I join in if there's anything going on. It's great fun." A visitor said, "They were playing bat and ball with a balloon yesterday." However, some people, especially those that spent most of the time in their bedrooms, were not happy with the activities provided. A person said, "I love choirs and music. I'd love to be able to go to the lounge if musicians were here but I miss out. No one comes along the corridor to play. I listen to the radio or watch my TV." Another person said, "No one comes to my room to help pass the time. I have my TV for company." A third person said, "It's all changed now. No regular events or outings. We're not encouraged to join in at the moment and don't know what's planned." A visiting professional felt that the levels of physical activity could be improved at the home.

Each person had a care plan for social activities. However they were limited in the amount of information given. One person's care plan stated they were not interested in the activities on offer. We saw that there was limited recording of people's participation in activities. Support staff described a range of activities that took place in the home and a few people were supported to visit the local village, however, they confirmed that there were no trips outside of the home taking place for groups of people so they were starting to plan these.

We were told that there were two activity staff, known as 'support staff'. One based on each floor, with additional part-time staff some afternoons. We observed these two staff talking to people in the lounge/dining areas, helping prepare people for lunch and giving support with eating as required. They assisted with drinks and settling people after the meal and sat in the lounge later. We saw little evidence of any activities on the day of our visit, with lounge TVs the only source of stimulation. In the morning we noticed a visiting vicar taking a short service in the ground floor lounge and giving communion if required. This meant people were not consistently supported to remain active, and to participate in activities that interested them.

We were told that the service had recently moved to an electronic care records system. Non-clinical staff had been employed to transfer most of the information to the new system and we found that care plans did not provide sufficient guidance for staff on how to provide people with personalised care. We were told that now the transfer of information had been completed, staff would be checking the information to ensure it provided staff with sufficient guidance.

We saw that care plans provided only basic information about people's care and support needs and often important information was missing. For example, mobility care plans did not contain information about the type of sling to be used when someone was moved using a hoist and tissue viability care plans did not always contain information about the pressure relieving mattresses or the frequency of re-positioning needed. In addition, there was frequently a lack of information about people's preferences and whether any religious or cultural requirements had been considered in relation to their care. This meant that there was a greater risk that people would not receive care in line with their preferences as staff did not have sufficient guidance in this area.

We reviewed the care of a person with diabetes. Their care plans indicated that they should be monitored for signs of low or high blood sugar levels but did not provide details of the symptoms to watch for or the specific action to take in response. There was no indication in the care plan of the need for an annual diabetes check or diabetic retinopathy screening, however, staff told us the person had received these services. Another person was at risk of seizures but their care plans contained no guidance for staff in this area. This meant that there was a greater risk that people would not receive appropriate care as staff did not have sufficient guidance in this area.

Complaints were generally responded to appropriately. People told us they knew how to make a complaint. No-one we spoke with could recall having the need to make a complaint. Most people told us they would speak to a care staff member out of preference. A relative told us that they had made a complaint regarding care provided to their family member but had not received a response. We did not see a copy of their complaint in the complaints folder we were provided with. Complaints we looked at had been handled appropriately and responded to promptly. However, a formal written response had not been provided to most complainants. This was not in line with the provider's policy.

Guidance on how to make a complaint was displayed in the home but not in the guide for people who used the service. There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them.

Requires Improvement

Is the service well-led?

Our findings

We saw that audits had been completed by the registered manager, other staff and representatives of the provider. Audits and checks were seen in the areas of medicines management, health and safety and care records. However, it was not always clear that actions had been completed in response to issues identified from the audits.

The medicines management audit required further development in order to be effective in auditing all areas of medicines management. We did not see evidence that an infection control audit was being completed regularly. This meant that there was a greater risk that audits in these areas would not be effective in identifying issues.

We saw a copy of an email sent to the registered manager following a visit to the home by a representative of the provider. This email was identified as a director audit and referred to an inspection of the environment of the home and a conversation with two professionals. No other checks were referred to in the email and did not demonstrate that the representative of the provider had carried out a comprehensive audit during their visit.

The operations director told us they met with the registered manager each month but there was no formal provider audit process in place at present. We were told that a quality assurance manager would be starting with the provider later in the year. We were told that a monthly home manager's audit would also be introduced with immediate effect.

Audits had not identified and addressed the issues we found at this inspection including premises safety and suitability, medicines, infection control, and documentation including pressure care records, care plans and MCA decisions.

We saw that commissioners had raised concerns in the areas of MCA documentation and the recording of the involvement of people in care planning in January 2017. We found that these issues were still present at our inspection.

We also saw that an infection control audit completed by the clinical commissioning group in May 2015 identified a number of issues and some of these were also present at our inspection.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with could not recall meetings or questionnaires where they were asked their views of the service. However, we saw a meeting for people and relatives had taken place in May 2017 where comments and suggestions on the quality of the service were made. Comments were positive. We saw completed surveys were also generally positive on the quality of the service being provided. A suggestion box was also located in the main reception area. We also saw a copy of a report produced by an external

body who had been commissioned to come into the home to talk with people using the service and ask for their views on the care they were receiving.

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in the policy. The provider's values were displayed and staff were generally observed to act in line with them during our inspection.

People told us that the home had a good atmosphere. A person said, "It's so friendly." Another person said, "It's very happy." A visitor said, "It feels good here." Another visitor said, "I find it has a nice atmosphere." Staff told us that the atmosphere of the home was friendly.

People had mixed views on whether they saw the registered manager. Those people that saw the registered manager told us that they found him approachable. A person said, "I pop in and out the office and chat to him. He lets me use their phone to call my wife for a chat." Another person said, "I see him now and then. He's got a good sense of humour and I could talk to him."

Staff told us that the registered manager and deputy manager were supportive and representatives of the provider were approachable. A staff member said, "[The registered manager] is very supportive." Another staff member said, "[The deputy manager] is firm but fair. The best nurse I've ever worked with." We saw that a range of staff meetings took place and the registered manager had clearly set out their expectations of staff though notes of meetings did not always make clear what actions were required to take place and by who.

Staff told us that they received feedback in a constructive way so that they knew what actions they needed to take. A clear management structure was in place and staff were aware of this. We were told that a staff well-being day took place each month which gave staff an opportunity to receive support and discuss any concerns they had. The service was involved in a project which was set up to allow it to understand how its staff felt and gather their feedback and ideas. This project involved staff being sent three surveys over six months. The first survey had been sent out in June 2017 and the next was to be sent out in September 2017.

A registered manager was in post but was on leave at the time of our inspection visit. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when 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 11 HSCA RA Regulations 2014 Need for consent People's rights were not fully protected under the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always managed so that people were protected from avoidable harm. Staff did not always follow safe medicines management and infection control practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

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