Wellfield and Henley House Limited

Wellfield

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?	**Requires Improvement**

Summary of findings

Overall summary

We visited Wellfield 18,19 and 25 September 2018 to carry out an unannounced comprehensive inspection.

Wellfield is a 'care home' which is registered to provide care and accommodation for up to 29 older people. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Nursing care is not provided at Wellfield. At the time of our inspection 24 people were using the service.

There was a registered manager who was also the provider. A registered manager is a person who has registered with the CQC 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.

At the last inspection on 9 and 10 August 2017 the service was rated 'Good'. However, we found the provider was in breach of one regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. This related to a lack of robust complaints management processes. Following the inspection, the provider sent us an action plan outlining the progress to be made. At this inspection we found sufficient action had been taken to make improvements.

At this inspection we found there was one breach of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach related to insufficient processes for monitoring and improving the safety and quality of the service.

We have also made recommendations on staff recruitment procedures, medicine management processes and person centred care. We also found some further improvements were needed with risks to health and wellbeing, monitoring staff deployment, the catering arrangements and the suitability of bathing facilities.

The service had a management and leadership team to direct and support the day to day running of the service. However, we found there were shortfalls in the auditing/monitoring systems and making plans for improvement in a timely way.

We found staff recruitment did not include all the required character checks for the protection of people who used the service.

Arrangements were in place to promote the safety of the premises, this included maintenance, servicing and checking systems. However, during the inspection we identified some areas were in need of attention.

There were enough staff available to provide basic care and support; people who used the service and staff had some concerns about the numbers of staff, however additional staff were being recruited.

People told us they felt safe at the service. Staff were aware of the signs and indicators of abuse and they knew what to if they had any concerns. Staff spoken with were aware of safeguarding and protection matters.

There were some safe processes in place to support people with their medicines, but we found improvements were needed.

Arrangements were in place to gather information on people's backgrounds, their needs, abilities and preferences before they used the service.

People made positive comments about the care and support they received from staff. They said their privacy and dignity was respected. We observed respectful and friendly interactions between people who used the service and staff.

Visiting arrangements were flexible, relatives and friends were made welcome at the service.

People said they were satisfied with the variety and quality of the meals provided at the service. However, we found there was scope for making improvements with the catering arrangements.

People were supported with their healthcare needs. Changes in people's health and well-being were monitored and responded to. Where necessary, people received appropriate medical attention.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems at the service supported this practice.

People spoken with had an awareness of the service's complaints procedure and processes. They indicated they would be confident in raising concerns. Processes were in place to receive and manage complaints.

There were adaptations and equipment to assist people with mobility and independence. There was a suitable standard of décor and furnishings to provide for people's comfort and wellbeing. We advised the suitability of bathing facilities be reviewed and planned for.

There were opportunities for people to engage in a range of group and individual activities.

There were arrangements for staff training, supervision and development. Some staff training was overdue; however, the registered manager was dealing with this matter.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe at the service. However, staff recruitment processes did not include all the required character checks for the protection of people who used the service.

We found medicine management practices needed some improvement for people's well-being and safety.

We found some risks to people's health and well-being were not always identified, assessed and managed in a timely way.

Staff knew how to report any concerns regarding possible abuse and were aware of the safeguarding procedures. People using the service and staff, raised some concerns about staff deployment, however we found action was being taken to make improvements.

Is the service effective?

Requires Improvement

The service was not always effective.

Processes were in place to find out about people's individual needs, abilities and preferences. People's health and wellbeing was monitored and they had access healthcare services.

People were satisfied with the quality and variety of meals provided. However, we found improvements were needed with the catering arrangements.

Arrangements were in place to develop and supervise staff in carrying out their roles and responsibilities. Some training was overdue; however, action was being taken to progress this matter.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People made positive comments about the caring attitude and friendliness of staff. During our visit we observed respectful, friendly and caring interactions between people using the service and staff.

People were supported to maintain contact with families and friends.

People's dignity and personal privacy was respected. People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were processes in place to manage and respond to complaints, concerns and any general dissatisfaction with the service.

Each person had a care plan which included their needs and preferences. Processes were in place to monitor, review and respond to people's changing needs and choices. However, there were some established routines, which were not responsive to individual needs and preferences.

People were supported to take part in a range of individual and group activities. Progress was ongoing to provide more meaningful activities and opportunities for engagement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of robust monitoring and auditing processes, to make sure people experienced safe, effective and responsive care.

There was a management team providing leadership and direction. People made positive comments about the management and leadership at the service.

There were processes in place to consult with people on their experiences at the service.

Wellfield

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We visited Wellfield 18,19 and 25 September 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of one adult social care inspector and an expert by experience who attended on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, social workers, district nurses and GP practices to obtain feedback about the service.

The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit we talked with eight people living at Wellfield about their experiences at the service and spoke with two visiting relatives. We looked round the premises and carried out observations in the communal areas of the service.

We spoke with two care workers, a care supervisor, two assistant managers, a cook, maintenance person and the registered manager. We also talked with three visiting healthcare professionals. We looked at a sample of records, including three care plans and other related care documentation, two staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with indicated they felt safe and secure at the service. One person said, "The staff pop in to make sure I'm okay and that reassures me." A visiting relative told us, "If [my relative] wasn't being treated well, I would be able to tell and she is very happy here." Comments from visiting health care professionals included, "I have never seen anything untoward. They are very good," "All the staff are lovely" and "Never seen anything of concern."

However, we looked at the recruitment records of two members of staff. The recruitment process included applicants completing a written application form and attending a face to face interview. Some of the required checks had been completed before staff worked at the services and these were recorded. However, we found there was a lack of information to show all the required checks had been appropriately completed. Two written references had been obtained for each applicant. But we found a reference from a previous employer had not been pursued, which meant evidence of the staff members conduct in a previous registered care setting had not been obtained. The application form requested an employment history from the previous 10 years only, this meant a full employment history, including any gaps in employment had not been checked and verified.

There was a recruitment procedure to support the process; this had not been reviewed and updated to reflect current regulations and guidance. The application form included an integral health questionnaire; we therefore questioned whether this met the requirements of employment law legislation.

The registered manager and administrator took action to make improvements during the inspection. However, we would expect all appropriate recruitment checks would be completed and recorded prior to staff commencing employment at the service.

We recommend the recruitment processes, policies and procedures, be developed in line with the regulations, to ensure there is sustained compliance for the well-being and protection of people who use the service.

The checks had included an identification check and a DBS (Disclosure and Barring Service) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Arrangements were in place for new employees to undergo a probationary period to monitor their conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

We looked at the way people were supported with the proper and safe use of medicines. People spoken with indicated they received their medicines appropriately and on time. Processes were in place to consider, assess and plan for people choosing and able to self-administer their own medicines. One person told us, "Medication is given by only one member of staff, so they can concentrate and explain things to us."

Records and discussion showed staff responsible for medicines management had received various levels of

training. We looked at records which demonstrated staff had been appropriately competency assessed in undertaking this task. Staff had access to a range of medicines policies, procedures and nationally recognised guidance which were available for reference.

There were no 'homely remedies' kept at the service, this meant people did not benefit from access to 'over the counter medicines' in a timely way. However, the registered manager indicated this provision was to be reviewed.

We checked the procedures and records for the storage, receipt, administration and disposal of medicines.The medicines storage room was found to be clean, tidy and secure. Appropriate administration was in place for controlled drugs, which are medicines which may be at risk of misuse. We noted the controlled drug cupboard was slightly moveable, however the registered manager assured us it had been appropriately secured to the wall. There was lockable fridge storage, however the key to the fridge was missing. Appropriate records were kept to monitor the temperature of the medicines storage areas and staff were instructed when to make adjustments.

We noted a lack of a 'tamper proof' container for returning unused medicines to the pharmacist and some medicines had not been accounted for in the returns log. The registered manager proactively contacted the pharmacy for an appropriate container to be supplied.

Each person had a 'medication profile' which included, a photograph of the person, prescribed medicines, diagnosis and known allergies. We suggested the profile be developed to provide person centred information on how and where, people preferred to take their medicines. There were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. These were to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered.

People with external medicines, such as topical creams, had recording charts with 'body map' diagrams for care staff to refer to and complete. We noted one instruction for cream application was lacking in specific detail, however, the registered manager took action to rectify this matter during the inspection. There were some gaps on the medicines administration records (MAR), the medicines audit processes had identified the discrepancies and action was being taken to make improvements. However, our findings indicated some shortfalls in medicines management processes had not been identified.

We recommend processes for auditing medicine management practices be further developed in line with recognised guidance, to identify and rectify shortfalls in a timely way.

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. Records and discussion showed arrangements were in place to check, maintain and service fittings and equipment, including hoists and lifts, water temperatures, and gas and electrical safety. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out. There were contingency plans to be followed in the event of failures of utility services and equipment. We talked with the maintenance person who describe the processes in place to attend to minor repairs and general upkeep. Arrangements were in place for the safe storage of records to promote confidently of information data protection.

We found some matters in need of attention. There were environmental health and safety risk assessments, however these had not been dated, monitored and reviewed. We were concerned about the lack of a radiator cover in one bedroom which presented as a health and safety risk and we noted some bedroom

doors were propped open and had not been fitted with alarm activated closures. During the inspection, the registered provided evidence to confirm action was progressing to rectify these matters. However, we would expect these risks to identified and managed without our intervention.

We reviewed how people were protected by the prevention and control of infection. People spoken with did not express any concerns about cleanliness at the service. The areas of the accommodation we looked at were kept clean. Rooms and corridors, toilets and shared spaces were very clean and fragrant. Staff were provided with protective personal equipment, including gloves, aprons and anti-bacterial hand wash was available. There were cleaning schedules and processes to audit, monitor and respond to infection prevention and control. Two visiting health care professionals told us the service was always kept clean. However, on the first day of our visit, we saw commode pans had been left to soak in bath which did not present as hygienic. The registered manager took immediate action to rectify this matter. Suitable cleaning equipment and laundry facilities were provided. We found the laundry room to be very dusty and cluttered flower vases which would make it difficult to keep clean.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. We looked at the staff rotas, which showed arrangements were in place to maintain consistent staffing levels. During the inspection we found there were sufficient staff on duty to meet people's basic needs. A visiting healthcare professional said, "There always seems to be enough staff around." However, two people spoken with told us the home was short of staff, others indicated they would prefer more allocated time to spend with staff. All the care staff we talked with told us they didn't have enough time to spend with people on a one to one basis. We found the registered manager was aware of the staff's concerns, they had identified the need for additional staff and recruitment was ongoing. The registered manager said staffing reviews were carried out in response to people's changing needs. As there was no structured staffing tool available, to help determine appropriate staffing levels and staff skill mix, we suggested such a process be researched and introduced.

We reviewed how people were protected from abuse, neglect and discrimination. Prior to the inspection we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We discussed and reviewed some of the concerns with the registered manager. We found action had been taken to liaise with local authority and other agencies in relation to the allegations and incidents. The service was working in accordance with the local authority's revised safeguarding protocols. Processes were in place to record and manage safeguarding matters, accidents and incidents, to reduce the risks of re-occurrence using a 'lessons learned' approach.

Staff spoken with expressed an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse, including physical abuse, psychological harm and potential discrimination. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received training and guidance on safeguarding and protecting adults. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. There was a whistle blowing (reporting poor practice) policy which staff were aware of.

We looked at how risks to people's individual safety and well-being were assessed and managed. Individual risks had been identified in people's care records. The risk assessments included: skin integrity, malnutrition, behaviours, the use of bed rails, mobility and risk of falls. Plans had been drawn up to guide staff on monitoring and responding to identified risks. The assessments were kept under review monthly or earlier if there was a change in the level of risk. There were personal emergency evacuation plans in the event of emergency situations. Most staff spoken with indicated an awareness of the risk assessments and keeping people safe.

Requires Improvement

Is the service effective?

Our findings

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. We spoke with two people who were new to the service and were still making adjustments to living in a shared environment. They described some of the arrangements made and planned for, to meet their needs. One person said, "Changes have been made to my room to make it easier for me to get around." The registered manager described the process of initially assessing people's needs and abilities. We reviewed care records which showed needs and preferences assessments had been carried out. Care plans were then developed in response to identified needs. People were encouraged to visit the service, to support the assessment process and provide people with the opportunity to experience the service before moving in.

We looked at how the service made sure that staff had the skills, knowledge and experience to deliver effective care and support. One person told us, "The staff here know their jobs." Processes were in place to support an induction training programme for new staff, where appropriate, this included the completion of the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

We found there were arrangements in place which aimed to provide staff with appropriate training and development, this included safeguarding vulnerable adults, MCA and DoLS, safe handling of medicines, health and safety, fire safety and first aid. Staff spoken with told us of the training they had received. However, on looking at the staff training matrix we noted some shortfalls in ensuring established staff received refresher training and not all ancillary staff had accessed the mandatory training. The registered manager was aware of the gaps in training and assured us action was being taken to address this matter with individual staff members.

Staff were enabled to attain recognised qualifications in health and social care. Most care staff had an NVQ (National Vocational Qualification) in care, or a QCF (Quality and Credit Framework) diploma in health and social care. Staff spoken said they received one to one supervisions. We saw records of the supervisions and noted plans were in place to schedule further meetings. Staff also received an annual appraisal of their work performance; this included a review of their performance and development needs.

We looked at how consent to care and treatment was sought in line with legislation and guidance. We observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. Staff spoken with described how they involved people in making decisions and asked for their consent before delivering care. One staff member said, "We always ask and involve people." The care records we reviewed included agreements on consent to care and other matters, families had been consulted on decisions as appropriate.

We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that capacity screening assessments were included in the care planning process. There were examples of relatives being involved in best interests decisions relating to their family members' care and support. Care records highlighted when people had capacity to make their own decisions. There was information to show action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. Records had been kept to monitor and review the progress of pending applications. Policies and procedures were available to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with said they had received training on the MCA. They were not aware of the DoLS applications, which meant they may not be fully aware of proposed restrictions on people's liberty. However, the registered manager proposed a way of sensitively alerting staff to this information.

We looked at how people were supported to live healthier lives, had access to healthcare services and received ongoing healthcare support. One person told us, they were receiving ongoing treatment from the local hospital and had regular appointments that the home were facilitating. People's overall health, medical conditions and support with healthcare, was included in the care planning process. Their wellbeing was monitored daily and considered as part of ongoing reviews. One visiting relative said, "The manager rings me if [family member's] health changes or they need to discuss anything." The service had access to remote clinical consultations; this meant staff could seek professional healthcare advice at any time. Comments from healthcare professionals included, "The patients are looked after well. All the staff here are always helpful. They go out of their way to help us. The managers act on things quickly and always report any concerns" and "They get in touch as need for any issues. They liaise well with all the GP practices." The service was part of the 'Red Bag Scheme.' This was an information sharing initiative, to improve the transition process when people accessed healthcare services.

We checked how people were supported to eat and drink enough to maintain a balanced diet. All the people spoken with said the food was good, plentiful and hot. Some people indicated that they could ask for anything at any time, others felt that the choice of food was given to them on their plate. One person said," I always enjoy the food. The rice pudding is lovely we can have jam on it if we wish!" A visitor told us, "The food looks nice [my relative] enjoys it."

People were routinely offered various choices at teatime. However, there was just one set meal offered at lunch time. Although alternatives could be provided on request, this approach did not provide optimum opportunity for offering choices. We noted the menus included some repetition, with same meals served on set days. We discussed the value of offering options with the registered manager and on the last day of our visit, we found the menus had been reviewed to include further choices.

Mealtimes were flexible and people could eat in their rooms if they preferred. We saw people in the dining room, enjoying the mealtime experience as a social occasion. The dining tables were attractively set with placemats, napkins and condiments. We also observed examples of people being sensitively supported and encouraged by staff with their meals. There was plenty of conversation and people were not rushed in any way. Throughout our visit, we observed people being frequently given drinks and help to drink them.

Individual dietary needs were known, food and fluid intake was monitored and their weight was checked. This helped staff to screen risks of malnutrition and support people with their diet and food choices. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary. Specific diets could be catered for, including fortified diets and pureed meals. One visitor told us they felt the service was fully aware of their relatives declining appetite and they were confident of the support being provided with meals.

Care staff spoken with expressed some concerns around the catering arrangements, including the carrying of hot food containers from the food preparation kitchen to the serving area. We found some meals were not always fully prepared before leaving the kitchen; this meant care staff having to spend time cooking and blending some foods prior to serving. We discussed the suitability of this approach with the registered manager who agreed to review the arrangements to make improvements.

We reviewed how are people's individual needs were met by the adaptation, design and decoration of premises. The home was furnished and decorated to a suitable standard. People had been supported to personalise their bedrooms. One person told us, "I love my room, I have it just how I like it." Equipment was available to support people with their mobility and comfort. There was some signage to help people with orientation. There were various type of bathing facilities to provide for individual needs and preferences. However, some were not suitable or accessible, to meet people's needs, which meant they had to move between floors to access bathing facilities. We discussed this situation with the registered manager and suggested a review of the suitability of the bathing facilities be included in the service's ongoing refurbishment plans.

Good

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. Without exception, all the people we spoken with and their made positive remarks about the staff at Wellfield. Their comments included, "The staff are caring, affectionate, kind and attentive," "I don't know how they put up with me!" and "All the staff are good to us." A relative said, "The staff talk to mum and give her a kiss, they are all lovely." We observed some patient and respectful interactions between people using the service and staff. Staff showed sensitivity and consideration when responding to people's needs and requests.

Comments from visiting healthcare professionals included, "All the staff are lovely," "They are very friendly, I like coming here" and "The staff are a happy bunch." A GP wrote, "I find Wellfield offer residents genuine compassion and care, there is a good continuity from staff and carers."

Most of the people spoken with told us staff didn't have enough time to spend with them and staff explained there wasn't always enough time for talking and time to listening to people. However, the registered manager was in the process of recruiting additional staff which should further promote the opportunity for meaningful emotional support.

We checked how people's dignity and individuality was upheld. People had care plans which recorded their individual needs and preferences and how they wished to be supported. Although people we talked with were not very aware of their care plans they indicated staff knew their needs and choices. Staff explained how they consulted with people and involved them in making decisions about the care they received. People had 'one page profiles' which included details on people's life so far, current and past interests, their work history and their specific likes and dislikes, such as 'places I like' and 'things important to me.' The profile also included a summary of the person's care needs for staff to refer to. Staff had received equality and diversity training. Equality is about championing human rights and diversity relates to accepting and valuing people's individual differences.

We reviewed how the service empowered and enabled people to be independent. One person told us, "There are no rules and regulations here [name of registered manager] says it's your home you can do want you want," another said, "Yes I like to be independent." Most people we spoke with indicated that they were supported to be as independent as possible. We observed people doing things independently and making their own decisions, some with staff support. Promoting choices and encouraging independence was reflected in the care plan process. Staff spoken with explained how they encouraged independence, in response to people's individual abilities, needs and choices. Staff told us, "We always try to promote people's independence" and "People here are supported to do things for themselves, for their independence and dignity."

We looked at how people's privacy was respected and promoted. All the bedrooms were single occupancy and bedroom doors were fitted with suitable locks to promote privacy of private space. People could spend time in the privacy of their rooms and some preferred to spend most of their time in their rooms. We saw

staff respecting people's private space by knocking on doors. We discussed with staff how they upheld people's privacy within their work, by supporting people sensitively with their personal care needs and maintaining confidentiality of information. We noted one bathroom door was not fitted with a suitable lock, however the registered manager said the facility was rarely used, but agreed to ensure a lock was fitted.

Positive relationships were encouraged and visiting times were flexible. People told us of the contact they had with families and friends. Relatives spoken with said they could call anytime and some visited daily.

There were notice boards at the service which provided information for people and their relatives. Included were forthcoming events, records of meetings and advisory information, such as local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. There was a guide to the service, providing details of the services and facilities available at Wellfield. Included was information about the management and care team, accommodation, visiting arrangements, complaints procedures and the aims and objectives of the service.

Requires Improvement

Is the service responsive?

Our findings

We reviewed how people's concerns and complaints were listened and responded to and used to improve the quality of care. At our last inspection we found the provider had not appropriately responded to or acted upon complaints. This had resulted in a breach of the regulation. At this inspection new found sufficient improvements had been made.

People spoken with indicated an awareness of the service's complaints procedures. Their comments included, "I am aware of the procedure, but I have never had to complain about anything" and "I was asked by the staff whether I wanted to lodge a complaint, I said no, but I was happy I was given the opportunity." We received some comments which suggested people had sensed some tension after raising concerns, but they told us this had soon passed and it had not put them off complaining.

We noted the complaints procedure, which was displayed in the service, emphasised the importance of raising any concerns. The procedure indicated that complaints would be taken seriously and carefully considered to resolve matters and make improvements. We noted the procedure did not include contact details for the local authority or local government ombudsman, however the registered manager took action to amend the procedure during the inspection. There were complaints forms available for people to complete. Staff spoken with expressed an understanding of their role in supporting people to make complaints and described how they would respond should anyone raise concerns. There were processes in place to record, investigate and respond to complaints and concerns. We reviewed the records of concerns and complaints received in the last 12 months. The records showed action had been taken to investigate and resolve the matters raised. We discussed with the registered manager, ways of ensuring the records provide a clear audit trail of the complaints management process.

We looked at how people received personalised care that was responsive to their needs. All the people we talked with, told us they felt well supported and cared for, they said, "They are looking after me alright," "I enjoy every minute of living here" and "We have good carers at night, they are always there for us." Each person had a care plan which was designed to meet their individual needs. The care plans and other related records we reviewed, included people's needs and choices. All care plans had been reviewed and updated where necessary to reflect people's needs. Staff spoken with knew people and were aware of people's individual needs, preferences, backgrounds and personalities. They said they had access to the care plans. People spoken with were not very aware of their care plans and records were lacking to show how people or their families had been involved in the care planning and review process.

We found there were established routine practices which did not reflect a person-centred response to people's individual choices, preferences and needs. An example of this was that none of the people living at Wellfield were supported to bathe or offered a bath or shower in the mornings. Some bathing facilities were not responsive to people's needs. Staff spoken with indicated there wouldn't be enough staff available to safely respond to this provision. One commented that bathing people in the evening 'fitted in with Wellfield,' which was not reflective of a person-centred service. It was evident that additional staff were in the process of being recruited and we discussed with registered manager ways of promoting person centred choices.

We recommend that the service continues to develop and introduce a person-centred approach when planning, delivering, monitoring and reviewing people's care.

People told us how their social needs were encouraged, some said they went out frequently with family or friends. They said entertainment and demonstrations were held at the home and they were encouraged to attend. We talked with the activities coordinator, who was new in post, they explained that an audit of activities was being carried out. People had been consulted individually on their interests, backgrounds, life experiences and skills. Efforts were being made to sensitively support people with similar interests in sharing in reminiscence discussions and group activities. The recent group activities had included drawing games and a 'tea and scone afternoon.' We were given specific examples of engaging with individuals, in response to their emotional and intellectual needs. We noted individual records were kept of people's interests and their participation in various activities.

Residents meetings were held; this provided the opportunity for people make shared decisions and be kept informed of any matters of interest. The records kept of meetings showed various topics, such as menus and activities. We did note there was no action plan following the meetings, this would show how people's choices and decisions were followed up and responded to.

We looked at whether the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

People's communication and sensory needs were included in the care planning process. The registered manager told us that the guide to the service and other information would be read to people. However, we discussed with ways of producing information, to help with meeting the expectations of the Accessible Information Standard.

End of life care was provided when necessary, in response to people's preferences and changing needs. The service worked with other agencies as appropriate, when responding to people's specific needs. The registered manager explained that any advanced decisions were agreed and recorded, to ensure care was delivered in line with the person's wishes.

Requires Improvement

Is the service well-led?

Our findings

We checked if the monitoring systems ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were identified and managed. Arrangements were in place for regular audits and checks to be carried out on processes and systems. We noted examples where shortfalls had been identified, addressed and kept under review as part of an action plan. However, we found shortfalls in safe staff recruitment processes. We also found some improvements were needed with medicines management processes, risk to health and wellbeing, the catering arrangements, person centred care, monitoring staff deployment and the suitability of bathing facilities. Some of these matters were responded to and rectified during the inspection process, however, we would expect such shortfalls and matters for development to be identified and addressed without our intervention.

We were told that management meetings were held regularly, however there were no records of such meetings available. This meant there was a lack of information to demonstrate how the management and leadership of the service, was organized and planned. We found there was no overall analysis and evaluation of the service in response to the findings of audit systems, consultation processes and potential changes in the care industry. Furthermore, there were no strategic action or business plans to provide vision and direction on the ongoing development of the service.

The provider had not ensured people who used the service were protected and assured by robust governance arrangements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of our inspection visit, we were shown a number of additional auditing and monitoring tools which were due to be introduced. We will check the effectiveness of these processes at our next inspection.

We reviewed how the service's management and leadership processes achieved good outcomes for people. People spoken with did not express any concerns about how the service was run. Comments from visiting health care professionals included, "The managers are very approachable and they act on things quickly" and "No problems with management. Things seem okay." Staff told us, "I think it's managed well. [the registered manager] is approachable. It's well organised" and "The management are good, they have been very good with me."

There was a management team in place which included the registered manager, deputy manager and care supervisors. The staff rota had been re-arranged to ensure there was always a senior member of staff on duty to provide leadership and direction. The registered manager was qualified and experienced to manage the service, they had updated their skills and knowledge by completing the mandatory training, attending seminars and accessing additional learning.

Staff spoken with expressed an awareness of their role and responsibilities. They had been provided with staff handbook, job descriptions and contracts of employment which outlined their roles and responsibilities. Staff had access to the service's policies and procedures.

Various staff meetings were being held. We looked at the minutes of the last staff meeting and noted various work practice topics had been raised and discussed. We found staff were enthusiastic and positive about their work. The registered manager had an 'open door' policy that supported ongoing communication, discussion and openness. Staff were very frank and forthcoming about their views and experiences at the service. They were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns.

The service encouraged feedback from people. There were various meetings held and there was a 'suggestion box' where people who use the service, visitors and staff could submit their ideas for improvement and development. There was an annual consultation survey with people who used the service and their relatives/representatives. The registered manager said the results of the last survey were due to be publicised in in the service's 'newsletter.' There had not been any staff surveys, we discussed with the registered manager the value of this consultation process to gain their views. We noted there were numerous cards of appreciation and thanks, for the care and attention people had experienced at Wellfield.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as, commissioners of service and the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had previously submitted notifications to CQC about incidents that affected people who used the service. We found one safeguarding allegation had not been appropriately notified to CQC. The registered manager assured us this requirement would be subsequently complied with and submitted a notification following the inspection. The service's CQC rating and the previous inspection report were also on display at the service, this was to inform people of the outcome of the last inspection.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were robust systems or processes to assess, monitor and improve the quality and safety of the services provided. (Regulation 17 (1)(2))