Bristol Care Homes Limited

Field House

Inspection report

Blakeney Road
Horfield
Bristol
BS7 0DL

Tel: 01179690990
Website: www.bristolcarehomes.co.uk

Date of inspection visit:
15 February 2017
16 February 2017

Date of publication:
28 March 2017

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

The inspection took place on 15 and 16 January 2017 and was unannounced. When the care home was last inspected in January 2016, there was one breach of the legal requirements identified. We found people's hydration needs were not fully met. The provider wrote to us with an action plan to tell us how they would meet the requirements of this regulation. During this inspection, we found actions had been taken to meet the specific requirements of this regulation. However, we identified three regulatory breaches with regard to the provision of safe care and treatment and record keeping.

Field house provides accommodation for up to 55 older people who require nursing or personal care. At the time of our inspection 48 people were living in the home.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

We found that medicines were not always managed safely. We also found risk assessments and risk management plans were not fully completed for some people with bed rails. Accidents and incidents were not always fully reported and recorded.

Staff demonstrated an understanding of the principles of the Mental Capacity Act. However, where people were unable to consent to care and best interest decisions were made on their behalf, they were not always fully recorded.

People's care records were not always personalised and monitoring records were not always up to date to reflect the care people had received. Audits were in place that had identified shortfalls although actions had not been fully completed to make the necessary improvements.

People lived in a clean and well maintained environment and checks were undertaken to make sure this remained the case. Equipment used to support peoples' care, for example, wheelchairs, hoists and pressure relieving mattresses were provided and readily available to meet peoples' healthcare needs. Equipment was serviced in line with national recommendations. We saw there were appropriate and adequate stocks of personal protective equipment such as gloves and aprons.

Safe recruitment procedures were followed before new staff were appointed. Appropriate checks were undertaken to ensure staff were of good character and were suitable for their role. The staff induction programme was comprehensive. Staff views were mixed about the support and supervision they received.

People were cared for in a kind and respectful way. People were supported to maintain their health and were referred to other external health professional when needed. Activities provided were varied and

responsive to individual needs and abilities. People were positive about the range of activities, events and outings provided for them.

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

The 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

Arrangements were not always in place to make sure people received their medicines appropriately and safely.

People were not fully protected because risk management plans did not fully mitigate the risks associated with the use of bed rails.

Accident and incidents were not always reported or recorded and sufficient actions were not always taken.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Good recruitment practices protected people from the employment of unsuitable staff.

The home was well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received initial and refresher training. Staff were not always supported with regular staff supervision.

Overall, people were protected by the principles of the Mental Capacity Act.

People were supported to eat and drink, and choices of meals were available.

People had access to, and were appropriately referred to health professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and who delivered care in a compassionate way.

People's dignity and privacy was maintained.

Positive relationships had developed between staff and people living in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Monitoring of care was not always accurately recorded. Care plans were not always personalised and people were not always involved in reviews of their care.

Records, such as fluid intake or positional change records were not fully completed.

People had opportunities to socialise and partake in activities and staff endeavoured to make these activities meaningful for people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People had not been fully protected by the provider's own monitoring systems.

People and relatives felt well supported and able to express their views and provide feedback.

There was no registered manager in post. Management arrangements were in place and a manager had been recruited.

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 15 and 16 February 2017 and was unannounced.

Prior to the inspection we reviewed all the information we held about the service since the last inspection. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed statutory notifications we had received from the provider. Statutory notifications are information the provider is legally required to send us about significant events.

The inspection was carried out by two inspectors and a specialist nurse advisor. During the inspection we spoke with 15 people who used the service, three relatives and two health professionals. We spoke with the provider's head of care quality, the deputy manager, the operations manager and 14 staff that included registered nurses, care staff, housekeeping, catering and activity staff.

We read care records for 10 people, checked how medicines were managed, observed how staff interacted with people, checked the use of equipment and reviewed records relating to the monitoring and management of the home.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always safely managed. Medicines were not always accurately recorded and people did not always receive medicines when they needed them. People were not always given their medicines at the time they were needed. Some medicines that should be taken before a meal were not always given at that time. We did see other examples of 'time critical' medicines being given at the correct times.

Topical medicines which are creams applied to people's skin, were not always managed in accordance with the person's prescription or with the provider's policy. We saw that whilst some people had creams prescribed, administered and signed for when applied, this practice was not consistent. We saw unlabelled creams in people's rooms, and incomplete recording to confirm the creams had been applied. We also checked other charts in place for recording checks on people's skin condition. They were not always fully completed which meant people may not have received the care and treatment they needed.

Where people were prescribed medicines to be administered as required (PRN), such as pain relieving medicines there was a lack of guidance to confirm the specific circumstances in which the medicines were needed. The effectiveness of the medicines when they had been given was not recorded. On some, but not all occasions when registered nurses were administering medicines, they reminded people and asked if they needed their prescribed pain relieving medicines.

One person received their medicines covertly, which means they were not aware they were being given their medicines. These medicines were being crushed and mixed with food or drink. The person's relatives and GP had been involved and agreed it was in the person's best interest to receive their medicines covertly and crushed. There was no evidence that a pharmacist had been involved or had assessed to make sure the medicines were safe to be crushed and would continue to be effective when mixed with food or drink.

Medicines were checked and amounts confirmed when they were received into the home. We observed medicines being given to people in the way they liked to take them and their preferences were recorded. For example, some people's records confirmed they liked to take their medicines from a spoon, or with a specific type of drink.

Some people were prescribed medicines that required additional security and these were safely recorded, stored and administered. No one in the home self-administered their medicines, however, arrangements were in place for people do this if they so wished and were assessed as safe to do so.

Risk assessments were completed and risk management plans were in place and updated on a monthly basis. These included risks associated with moving and handling, skin condition and risk of developing pressure ulcers, nutrition and weight loss and falls. Risk assessments were also completed when equipment such as bed rails were used. However, we noted risk assessments and management plans were not fully completed around the use of bed rails. The risk assessments had not considered the risk arising from the height of the bed rails above the mattresses that did not meet the minimum height stated by the of the

Health and Safety Executive (HSE) guidance. The guidance is provided to minimise the risk of people falling or rolling over the top of the bed rails. During the inspection we saw two people with their legs over bed rails that did not meet the minimum height requirements. We measured a further two bed rails at random and these did not meet the height requirements. We reported these findings to staff at the time. Senior staff told us they would address the shortfalls we had raised.

Accidents and incidents were reported and recorded in the care records and on incident and accident forms. A relative told us, "Dad had a fall the other day and they called my sister right away to let her know". We looked at the forms in use. The head of care quality had completed regular monitoring and reviews and had provided advice and guidance to senior staff in the home to improve the standard of reporting and recording. We found further improvements were needed.

One accident that had occurred the week prior to our visit had not been reported on an incident form. The person's care records stated, 'An accident form must be completed for each fall giving details of the fall. This must be signed and dated by the reporting nurse and returned to the office for the nurse manager to read and sign.' We also found sufficient actions had not been taken when a person was noted to have an unexplained bruise the week before our inspection. A further incident had occurred where a person was seen by the GP because they told staff they had taken a drink of a topical application. Appropriate actions had been taken at the time and the person was not adversely affected. However, staff had not completed the accident or incident reporting procedure. Senior staff were not aware of this incident until we brought the matter to their attention.

The above shortfalls in management of medicines, risk and incident management amounted to breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. Comments included, "Yes I'm safe enough in here" and, "Safe and secure, and staff around when I need them". A relative told us, "The overall feel here is great and I know Dad is safe". In addition to the provision of call bells, people were provided with portable pendants so they could call for help or support when they needed it. One person said, "The care is very good and if I press my pendant bell I get quite a quick response".

Staff were able to describe their responsibilities for keeping people safe from harm and avoidable abuse. They told us they had received training and explained they would report to senior staff or to external agencies such as the local authority or the Care Quality Commission if they had concerns people were being abused. We received concerns from staff during the inspection that we passed to the provider to address under their whistleblowing procedures.

Appropriate staff recruitment processes helped to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed that appropriate checks had been carried out before the staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps explored at interview. For example, one member of staff had not worked for a considerable period of time before they were employed at Field House. The reasons for this were recorded, and character references were obtained.

People and relatives told us there were sufficient staff to meet their needs. One person told us, "There's always staff around, often see them up and down the corridor and just call if I need them".

We received mixed feedback from staff about staffing levels. Some staff told us they were often short and this meant care was sometimes rushed. The head of care quality acknowledged they had experienced staff recruitment challenges. They told us this had improved and they had successfully recruited to most vacant posts and had just one remaining staff vacancy. We looked at the staffing rotas that stated the required and the actual numbers of staff on duty. The rotas indicated there had been some shortages in the four weeks prior to our inspection. Following the inspection, a representative for the provider sent us additional information and told us that correct staffing numbers had been maintained. They told us the actual staff numbers on each shift were recorded on daily staff allocation sheets. They told us they had sufficient staff on each shift, and the staffing numbers had been reduced when the numbers of people living in the home had reduced. However, we spoke with senior staff and care staff that were not aware of this planned reduction in staffing levels.

The head of care quality told us the provider had agreed to support and jointly fund a major regional recruitment and training initiative led by another local care provider. Their aim was to address what they described as the shortage of nurses for care homes and attract the next generation of care staff.

The environment was safely maintained. The maintenance team carried out numerous health and safety checks to ensure this remained the case. We saw well maintained records which recorded frequent monitoring and servicing of various systems and equipment. Contracts were in place with various service providers and maintenance companies. For example, for servicing and maintenance of lifting equipment, this included the passenger lift, bath and portable hoists and slings. Checks were completed for legionella and gas and electrical checks were completed and records maintained. Similar arrangements were in place to maintain the nurse call system, emergency lighting, fire alarm and fire safety equipment.

The provider had a contingency plan in place that provided guidance and instruction for actions to take in the event of an emergency, or if the care home had to be evacuated. Summaries of people's personal emergency evacuation plans were completed and copies kept in an emergency 'grab box'.

Requires Improvement

Is the service effective?

Our findings

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

We saw examples of mental capacity assessments for specific decisions such as 'to live and have care at Field House'. The mental capacity assessments asked whether the person could understand, weigh, retain and communicate the information related to the decision.

However, where people could not make decisions, the records showed that best interest decisions had been made. These included decisions, for example, to use bed rails. Some of the records did not provide detail of the involvement people or relatives had in the decisions made or that other less restrictive options had been considered.

The staff we spoke with showed a good understanding of consent. We observed one of the care staff enter a person's room, while we were visiting the person, to offer to help the person help to have a shower. The person was pleased with this. The care staff told them "I'll get your bits and pieces ready. Then we'll be off". We observed the member of staff showing and then asking the person which clothes they would like to wear that day.

We saw that people had a 'consent to care and treatment form' which was signed by the person or with support and discussion with a relative to confirm that care plans and risk assessments had been discussed and agreed.

We recommend the service refers to guidance in the Mental Capacity Act Code of Practice in reference to recording best interest decisions. The provider's policy was not always followed and staff had not always completed the provider's 'best interest meeting record.'

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).

No one in the care home had an authorised DoLs, although applications had been made for 16 people. We spoke with staff that demonstrated an understanding of what was meant by DoLS.

We received mixed feedback from staff about the support they received. Some staff told us they felt supported in their roles. One member of staff commented, "I've never known a company be more supportive". Other staff told us they had not received supervision on a regular basis. For example, one member of staff told us, "I can't recall when I last had a supervision".

The head of care quality told us they had spent a lot of time in the home because there was no registered manager in post. They told us they took time each day to speak with, supervise, direct and support staff with their day to day roles. These discussions were not always recorded and the records showed that staff had not all received supervision in line with the provider's policy.

Staff spoke positively about the induction they had received when they started in post. A member of staff told us, "It [the induction] was brilliant, the owner even popped in to introduce themselves". The induction programme had been recently reviewed and included four days 'classroom based' training, before staff started working in the care home. The induction programme included the Care Certificate. This lays down a national framework of training and support which new care staff should receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed.

Staff told us they had received sufficient training and updates for training they referred to as 'mandatory'. This included health and safety, infection control, moving and handling and safeguarding. Thirteen members of staff had completed dementia awareness training and told us this was really useful. One member of staff said, "It [the training] helps you understand people better".

The method of delivery of mandatory refresher had been reviewed. The head of care quality told us that some staff had repeatedly not attended when their updates were due. The programme had been revised and a new system was being implemented. Every member of staff was now required to book themselves onto one of the two day training programmes being delivered each year. This was to ensure all staff completed their training updates when they were due.

The head of care quality told us how they provided one to one support for registered nurses to support them with their professional Nursing and Midwifery Council (NMC) registration and revalidation process. Registered Nurses are required to demonstrate their fitness to practice in
line with the requirements of their professional registration.

People had access to GPs that visited weekly and to other health professionals. One person told us they could, "See a doctor [when needed], it's up to the individual". Another person said "I'm waiting for an eye test", and told us the optometrist was due to visit the home to do this. We met a speech and language therapist (SALT) from a rehabilitation team who was visiting the home. We were told the working relationship with the home was good and that staff were, "Very on the ball with care". We saw the service had liaised with the community mental health team to assess and provide guidance about how best to meet a person's needs.

A relative of a person with complex health needs spoke positively about the care the person had received since they moved into the home. They told us the person had, "Been pretty stable".

The provider employed a physiotherapist who worked across the provider's group of care homes.
There was an agreement for them to assess everyone admitted to the home if it was needed. Following this initial assessment additional arrangements could be made to access the service on a regular basis. They told us in addition to the wheelchairs provided for everyone to use the provider supplied specialist wheelchairs with pressure relieving cushions for people that were assessed as needing them. They told us they were, "Very proud of their [the provider's] fantastic provision".

People assessed as at risk of developing or who had a pressure ulcer, had pressure relieving mattresses in place with automatic settings to make sure they provided the most optimum support each person needed.

We observed meals served in the dining rooms and to people's rooms. People told us they could choose what they wanted to eat. One person told us, "I have what I want [to eat]. I am fussy, but I do like omelettes". They told us they were given omelettes when requested. We saw people being supported to make choices. For example, one person was shown two different yoghurts by a member of care staff and they were able to point to the one they wanted. We saw people that needed help and support being assisted with their meals. Jugs of water or other soft drinks were readily available for people in their rooms.

We spoke with a senior member of the catering team. They told us they were provided with information about people's individual dietary needs from the senior nursing staff. They also visited people after they had moved into the home and, if people were able to express their views, discussed their likes, dislikes and preferences with them.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff, and we received comments such as, "I was a nurse and I know the care is good","Staff are very kind" and, "I know that staff are kind and Mum is well cared for".

One person told us the home was a really nice place to live and that staff provided the help and support they needed. Another person had initially moved into the home on a temporary basis. They told us, "It's all so good here, I wanted to stay".

We were speaking with a person when they told us, "I don't know what I want". They confirmed they would like us to call a member of care staff for them, which we did. The person appeared pleased to see the member of staff and told them, "I love you".

Staff told us how they made sure people's privacy and dignity was maintained. They gave us examples, such as how they knocked on peoples doors before entering. They told us how they were sensitive to people's individual needs when providing personal care. One member of staff told us, "I try my very best every day to make sure residents are treated well and explain everything to them. We all know about important things like how important it is not to leave people uncovered when they are being washed". Another member of staff told us how important it was to be sensitive to people's needs They spoke fondly about the people they provided care for and told us, "So many lovely residents' here. When I come to work it's like visiting my Nan".

We observed staff kindly reminding people about plans they had for the day. For example, a member of staff told one person, "[Name of relative] is coming today to visit and you're going out on a trip later". The person appeared reassured and smiled in response to the member of staff.

We observed staff assisting people and this was done with dignity and understanding. For example, we heard staff gently encouraging people to visit the lounge where entertainment was taking place. We heard a member of staff commenting to one person, "I'm sure it will be fun". However, the member of staff waited until the person had made their decision before they provided the support the person needed.

Staff were knowledgeable about people's care and treatment needs, and told us how different people liked to be cared for. One member of staff told us, "It's so important to be patient because some people might be confused and don't really want us to give them personal care so we need to talk with them first and sometimes leave them and come back later". It was evident, through our observations, that there were good caring relationships between people and staff.

We read the end of life care records for one person. The records were detailed and personalised. They provided clear guidance about the person's expressed wishes and preferences and included details of what was important to them. The GP and senior staff held regular reflective meeting to review and discuss how people's end of life care had been managed and to identify any further improvements could be made.

We read the five compliments received since the beginning of 2017. One was from a relative of a person who had passed away recently. The card read, 'Thank all the carers for the kind and caring way they looked after my mother…we cannot praise them highly enough'.

Requires Improvement

Is the service responsive?

Our findings

Some people had individual monitoring charts in place to record, for example, their fluid and dietary intake, skin condition and change of position. We checked the charts at random and found they were not consistently or fully completed. For example, fluid charts did not specify the target amounts of fluid people required each day, and some charts did not record the total amount people had actually taken on a daily basis. Where people needed to be repositioned, the frequency of position changes people needed were not always recorded. This meant peoples' care may not be accurately assessed or reviewed to continue to meet their needs. We brought these shortfalls in recording and monitoring to the attention of senior staff during our inspection

Care plans did not consistently provide evidence that care had been completed in response to people's specific needs. For example, one person had a catheter in place. They had a detailed care plan that included the instruction to document the catheter care and ensure a related procedure was completed weekly. There were no records to confirm this procedure had been completed since 15 January 2017. We brought this to the attention of a registered nurse at the time.

The failure to provide accurate and up to date records of people's care was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were assessed by a manager or senior staff before they moved into the home, so their needs would be known. Risk assessments and care plans were completed electronically and updated on a monthly basis. Some care plans were detailed and provided personalised and detailed information. Others lacked detail and did not provide information relevant to the person. For example, they did not provide information about people's choice of getting up and going to bed times, where they liked to spend the day, or other day to day routines. This shortfall had been recognised in the provider's most recent audit and monitoring visits. Actions had been planned but had not yet been completed to make the required improvements. A senior member of staff told us, "Our care plans are not that good. It's not person-centred. Some of them are okay, not all of them".

Most of the reviews we read stated the care plans remained the same. Whilst there was initial evidence of people and relative involvement, there was inconsistent recording to confirm people or their relatives were involved when care plans were reviewed or updated. Comments from people and relatives included, "I don't think I've seen a care plan" and, "No I haven't been asked [to a review meeting]".

A 'This is me' document had been completed for some people. This was located in people's rooms and was designed to provide personalised information about people's lives, likes, dislikes and preferences. The quality of information recorded was inconsistent. Some documents had been completed, however, staff we spoke with told us they were not aware of the contents. One of the documents we saw dated back to 2014 and had not been updated. We brought an example of this to the attention of a representative of the provider.

We spoke with care staff who told us when they were new in post or had been away from the home on leave, the information they needed to help them provide personalised care to people was not readily available. They told us they gained information about people's day to day needs from people themselves or from other care staff. One member of staff told us, "The care plans really don't tell us that much". Staff were in the process of introducing laminated sheets that provided a quick guide about peoples day to day personal care needs, choices, likes, dislikes and preferences. In addition to the staff handover meetings, additional daily briefings had commenced with the aim of providing staff with up to date information about the people they were providing care for.

An activities coordinator was employed and they were supported by two volunteers. A weekly activity programme was available and a copy of the programme was given to each person in the home. One person told us, "I enjoy the activities and [name of staff member] who organises them. I went to the Forest of Dean in the minibus looking for wild boar". Other people spoke positively about the range of activities offered during the week and one person said they went out, "Every now and again when I want to". One person commented about the lack of weekend activities and told us there was, "Not enough to do and I was always a busy person".

On one day of our inspection, six people went out on a trip in the minibus. There were last minute changes to the destination because of poor weather conditions. On the other day of our inspection musical entertainment was provided and attended by 12 people and visitors.

The activity coordinator told us they provided one to one support to people who chose to stay in their rooms or who were unable to access the communal areas of the home. They told us they tried to make sure they made best use of the time available and provided what people wanted. They gave examples of what they did when they spent time with people in their rooms. They told us, "We make sure it's [the time spent with people] what the person wants and if they can't tell us we ask their family". They gave examples, and told us they sat and chatted with people, read books or newpapers, gave manicures or played games. They told us how they had developed community relationships, such as with the local school. They told us the recently appointed manager was encouraging them to make the lounges, "More interesting" for people.

People and their relatives felt able to complain or raise concerns. A relative commented, "I would [complain] if I needed to". Another person told us they would tell somebody if they were concerned about their care. They said, "Yes, if it wasn't satisfactory to my wants. My wife isn't the type that would sit back". A complaints procedure was available. We looked at the complaints received during 2016 and saw complaints received were responded to in line with the provider's procedure.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the home in January 2016, there was no registered manager in post. There was a manager, however, they did not complete the registration process with the Care Quality Commission and left in October 2016. Since that time the deputy manager had taken an acting manager role, supported by the Head of Care Quality. A new manager was appointed in January 2017, and we were told they would be submitting an application to the Commission for the post of registered manager.

A range of care and quality monitoring audits had been completed on a regular basis. A number of quality metrics, such as accidents and incidents, pressure ulcers, falls, medicine errors, safeguarding reports and care plans were reviewed and 'traffic light' scores applied with the reasons for the rating clearly stated. We found that some improvements had been made within the home from areas identified in the audits. However, these were not consistent and improvements were not being sustained. For example, in December it was recorded that falls management had improved. We checked care records for the two weeks prior to our inspection and found, as reported in the 'safe' section, a fall had not been appropriately recorded and reported. In May 2016, the care plans were reported as, 'Quality variable and often generic not person centred or individualised'. In December 2016, the review stated the care plans were, 'Very poor. Inappropriate interventions that do not relate to the person, show no involvement'.

The senior management team met with the chairman of the company on a quarterly basis when they discussed and reviewed all matters relating to the performance and quality of care within the home. Several new quality improvement measures had been devised and had either been implemented or implementation dates were planned. These included a range of new policies and procedures, an improved staff induction programme, a mandatory refresher training programme, improved staff recruitment procedures and enhanced staff supervision documentation.

Staff meetings were held regularly and staff were given the opportunity to contribute to the agenda. We looked at the minutes of the most recent meeting. One of the topics for discussion were the care plans which were noted as being, 'Not adequate'. We spoke with staff who told us if they were unable to attend meetings they were provided with the meeting minutes.

We saw environmental quality audits had been completed and actions taken to make improvements were evident. For example, where room audits identified furnishings were worn, actions were recorded that confirmed when replacements or actions would be taken.

People and relatives told us they were satisfied with the management of the home. We saw that people and relatives had the opportunity to provide feedback and express their views. Suggestion boxes were located in the reception area and a 'You said, we did' board had been installed. This was a means of communicating issues that had been raised and confirmed the actions taken. In addition a resident survey was due to be sent out during February 2017. A resident meeting was planned for 15 March 2017.

We spoke with staff who mostly told us that Field House was a good place to work. One member of staff told

us, "The ethos of the company is really good".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to service users were not always mitigated and accidents and incidents were not always fully identified and reported. Medicines were not always properly and safely managed. Regulation 12 (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and up to date records of care were not always maintained Regulation 17 (2) (c)