Fieldside Care Limited t/a Fieldside Care Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

Fieldside Care Home provides accommodation and personal care to older people, some of whom were living with dementia. The service is registered to accommodate up to 33 people. At the time of our inspection there were 29 people using the service.

This unannounced inspection took place on 27 October 2014. At the previous inspection of the service on 10 December 2013, the service met the regulations we inspected.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission (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.

Medicines were not always managed and administered safely. There were unexplained gaps on the medicine administration record (MAR). Medicines were not always

Summary of findings

administered in line with people's prescription. This meant there was a breach of the regulations and you can see what action we told the provider to take at the back of the full version of the report.

Recruitment process was not always safe and robust to ensure people employed at the service were suitable to work at the service. Appropriate criminal record check was not obtained before a person employed by the service started work. This meant there was a breach of the regulations and you can see what action we told the provider to take at the back of the full version of the report.

Staff were knowledgeable in recognising signs of potential abuse and followed the required reporting procedures. Staffing levels was planned considering the needs and dependency levels of people using the service. The service was covered 24 hours by staff and there were procedures in place for staff to follow in the event of unforeseeable emergencies.

Staff were supported by their manager through trainings, regular supervisions and appraisals. Team meetings took place with staff and the manager to discuss concerns regarding the people they supported. Staff had qualifications in health and social care.

People's needs were assessed and care plans were developed detailing how needs identified would be met. Staff liaised with other healthcare professionals to ensure people received the care and support they required. Staff were patient and kind in the way they supported people with their needs. People's dignity and privacy were respected.

There were a range of activities that took place at the service to stimulate and occupy people as they wished. People and their relatives were involved in decision making about their care and support.

The manager was approachable and operated an 'open door' policy so people had access to her anytime when they wished. There were no effective processes and systems for auditing and checking the quality of service provided.

We have made a recommendation about assessing and monitoring the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

There were aspects of the service which were not safe. Medicines were not always administered safely. There were gaps on the medicines administration record sheet (MAR) and people's medicines were not administered as prescribed

Recruitment was not always safe. Appropriate checks were not always conducted before new members of staff started work

Staff were knowledgeable in recognising signs of potential abuse and followed the required reporting procedures.

Assessments were undertaken to identify any risks to people and management plans were put in place to prevent or reduce risks from occurring.

Requires Improvement

Is the service effective?

The service was effective. Staff received the training they required to do their jobs effectively and to meet people's needs.

People had access to food and drink throughout the day. We observed staff supporting people to eat and drink and they did this in a polite and kind manner. Staff liaised with other health and social care professionals as required to ensure people's needs were met.

The requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and the Deprivation of Liberty Safeguards (DOLS) were met. Best interests' assessments were held with people's relatives and other professionals where people were not able to make decisions about their care.

Good

Is the service caring?

The service was caring. People who used the service and their relatives described staff as "caring" and "kind". Staff were polite and respectful, maintained people's dignity and right to privacy.

People and their relatives were involved in planning and making decisions about their care.

Good

Is the service responsive?

The service was responsive. Assessments were undertaken and care plans developed to identify people's health and support needs. Care plans and risk assessments were updated to reflect any changes in people's needs.

There were a range of activities available at the service for people to participate in each day to reduce the risk of people becoming socially isolated.

Good

Summary of findings

We observed staff being responsive to people's requests and wishes, and observed calls bells being answered promptly.

The manager held meetings with people to obtain feedback and to consult with them about the service. A complaints procedure was in place and we saw that the registered manager responded to complaints in a timely manner.

Is the service well-led?

Requires Improvement

The service was not well-led. People told us that the manager listened to them. Staff told us the manager was available and approachable.

There were no effective formal processes in place to assess and monitor the quality of the service.

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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 was 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 carried out an unannounced inspection to Fieldside Care Home on 27 October 2014. The inspection was conducted by one inspector. Before the inspection we reviewed the information we held about the service which included notifications of incidents.

During our inspection we spoke with the registered provider, registered manager, five care workers, four people who used the service and three relatives. We reviewed the care records of six people who used the service, four staff files and records relating to the management of the service including complaints and health and safety systems records. We carried out general observations in communal areas and during lunchtimes. We used the Short Observation Framework for Inspection (SOFI) during lunchtime in the main dining area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we spoke with two members of the local authority commissioning team. We also spoke with a specialist nurse who carried out assessments and provided support on palliative care.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I feel safe and secure", and another said "I feel safe and there is nothing for me to worry about". However, there were aspects of the care, which were not safe.

People's medicines were not always handled and administered safely. We looked at the medicine administration records (MAR) four weeks prior to our visit and found six unexplained gaps relating to five people. We checked the blister packs and the medicines were not in the packs. We could not establish if the medicines were administered or not. Medicines were stored in a locked cabinet. However, the blister packs which contained people's medicines were not securely packed and sealed to ensure people's medicines were well protected. On three different occasions during our inspection, we saw medicines fall out from the blister packs when staff were taking them out from the cupboard. Staff checked to see from which person's blister pack the medicines had fallen, but were unable to establish this at the time. Staff told us that the blister packs may not have been sealed properly and they told us they would speak to the pharmacist about it. We were concerned that people may not have received all their prescribed medicines to maintain their health if the medicines had fallen off from the packs.

People's medicines were not always administered in line with their prescriptions. On the day of our inspection, we observed one person being given their morning medicines at 4pm. We spoke with staff about this and they told us that it was the person's pattern and choice. However, there was no information from the person's GP to confirm that the medicines could be taken later in the day. Therefore, we could not be confident that people received their medicines as required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment practices were not always safe to ensure that only suitable staff were employed to work at the service. The service conducted interviews and obtained references before they were offered jobs. We saw record of criminal record bureau (CRB) or disclosure and barring service (DBS) checks for three out of the four staff files we looked at. However, there was no CRB or DBS check in place for one new staff member who carries out domestic tasks before they started work. The Adult First check, which checks to see if an applicant is barred from working with people in need of support, had not been carried out. The registered manager told us that they had applied for a DBS check and was waiting for the outcome and that the staff worked under supervision with another staff member at all times. We could not be confident that only suitable staffs worked at the service to ensure people were safe. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff understood the various types of abuse, the signs to identify possible abuse and the procedures they would follow to report it. Staff told us that they would report any concerns of abuse or the safety of the people they looked after to the registered manager who would then take appropriate action.

The manager undertook risk assessments to identify risks to people's care and support and management actions put in place to address where risks were identified. We saw that relevant health professionals were involved where necessary to assess risks and in drawing up management plans to ensure people were supported by staff appropriately. For example, community psychiatrist nurse had devised a behaviour management plan for a person. We saw that staff followed the plan.

Incidents and accidents were reported appropriately detailing the nature of the incident and those involved. We looked at some copies of completed incident forms and saw that they were reviewed by the registered manager and followed up. For example, risk assessments were updated following incidents of falls and we saw where other professionals had been involved as a result of reoccurring incidents involving the same.

There were sufficient staffing levels at the service. We observed staff responding promptly to call bells and supporting people during meal times. The registered manager told us that the staff rota incorporated additional staff to cater for emergency absence. Staff told us that there were enough of them on duty daily to meet people's needs. One staff member said, "We do not feel rushed." Another said, "We take our time to make sure we support the people we look after safely."

Requires Improvement

Is the service safe?

There was a procedure in place for staff to follow in emergencies. Most staff had completed first aid training. Staff knew how to contact emergency services if required. The registered manager and senior staff were on-call if required in emergency. Staff understood the procedure.

Good

Is the service effective?

Our findings

A relative of a person who used the service told us that "Mum has improved and doing very well since she moved into the service." Another relative told us "[s/he] is well looked after and staff understand her needs".

Staff were trained, experienced and knowledgeable in their roles and responsibilities. Staff we spoke with had completed the Diploma in Health and Social Care at levels two and three. The majority of the staff had worked at the service for many years and understood the needs of people who used the service. New staff went through a period of induction which covered the day to day operations of the service, policies and procedures, health and safety and the needs of people who used the service. Staff received regular supervision and annual appraisals which provided them with the opportunity to raise any concerns regarding their jobs and to discuss performance.

Staff told us that they had enough training to do their jobs. One staff member said, "There is plenty of training here." The training record showed that staff were up to date with training such as safeguarding adults from abuse, infection control, fire safety, moving and handling and first aid. Staff also benefitted from training delivered from the local authority learning and development team. Specific training such as dementia awareness, pressure sores, catheter care and palliative care were delivered by professionals in these areas. Staff we spoke with demonstrated their knowledge and skills in caring for people they looked after and they explained how they applied the knowledge gained through training in every day practice.

Most people were supported to make their individual decisions about their care and support. Relatives and other professionals were involved where people were unable to make a decision independently. Staff were able to demonstrate that they understood the issues surrounding consent and how they would support people who lacked the capacity to make specific decisions. For example, they said they would give people alternatives so they could make a choice and they would use communication methods appropriate to the person's need. We saw that appointeeship had been arranged for some people who did not have the capacity to manage their finances. The relevant professionals and the person's relative had been involved in this process. We also saw that some people had made the decision for their relatives to support them in managing their finance.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the Mental Capacity Act 2005 (MCA) and in the DoLS. All staff we spoke with understood that people's liberty could not be restricted without authorisation. One person was subject to DoLS and the correct process had been followed. We saw records of mental capacity assessments in people's files for specific decisions as required. For example, one person had assessment in relation to accessing the community independently without support from staff.

People were provided with food and drink throughout the day and staff supported those who required assistance. The atmosphere was relaxed and people ate at their own pace. Staff moved around to assist people as required. For example, staff assisted people to cut up their food into smaller sizes to make it easier for the people eat. Those unable to feed themselves were supported by staff to eat and drink as required. People who stayed in their rooms were also supported by staff.

People told us that they enjoyed their meals. One person said, "The food is always nice." Another person told us, "We have enough to eat." The menu showed a range of food including vegetables and fruits making a balanced diet. Staff explained that people could request for other options beside what was on the menu. People told us that they did not always know the choices available to them but they were happy with what they were offered. One person said, "We don't choose, they know what we want and they give us." People dietary requirements were met. For example, people were offered pureed diets as required.

Fieldside Care Home had access to a range of healthcare services such GP, dentist, chiropodist and community nurses who visited people as required. A relative told us that the dentist, chiropodist and GP visited the service often and we saw record of professionals' visits to confirm this. Staff arranged appointments with healthcare services and supported people to attend. Referrals were made to specialist teams where required. For example, we saw the involvement of a psychiatric team and dieticians. We also saw evidence that staff followed recommendations made.

Good

Is the service effective?

For example, a pureed diet was offered to some people as recommended by a dietician due to swallowing difficulty. The registered manager told us that they were able to contact these professionals for advice when required.

Good

Is the service caring?

Our findings

A relative described the staff as "caring and helpful". Another relative said, "Staff are genuinely caring and interested in the people they care for." We saw staff talking to people in a polite and respectful manner. One person using the service told us that "Everyone here is nice." Another person said, "They care for us." We saw positive interactions between staff and people.

People's care plans indicated their likes and dislikes and what they preferred to be called and we saw staff addressing people in the way they wanted to be addressed. People's preference for what time they got up, where and when they had their meals and how they had their personal care needs met were respected. For example, we saw that people had their meals in their rooms or in the lounge instead of the dining area. We also saw that one person who chose to stay in bed during the morning was able to.

People were involved in their care planning and where people did not have capacity to make decisions about their care, their relatives and other health and social care professionals were involved. One relative told us that, "We were involved in the care planning and had the opportunity to contribute to how [their relative] should be cared for." Another relative said, "We told them [staff] what mum likes and what she doesn't like, they follow it and it works well." Relatives told us that they were kept informed about their relatives' progress and well-being. Staff understood the needs and preferences of people they cared for and respected these. Care records detailed people's personal histories and backgrounds. Staff we spoke with told us they have learnt how to support people in the way they want by reading through their care plans and listening to their stories. This has helped built positive relationship between staff and people using the service.

We saw staff supporting a person who was agitated and distressed. They offered the person reassurance and spoke with them calmly. The staff member stayed with the person until they were settled. Staff knocked on people's rooms before entering and asked for their permission to enter so that their privacy was respected. We observed staff asking people discreetly if they needed support with toileting to respect their dignity. People were encouraged to be as independent as possible. For example, one person assisted in laying the dining table at lunchtime. People's personal matters were discussed privately to respect their dignity and privacy. For example, discussions about people's needs took place in a quiet room.

There were records of people's decisions about end of life care. We saw that people, their relatives, GP and palliative care nurse had been involved in making decisions about Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and care plans had been develop to reflect this. Staff understood people's decisions regarding this and knew what to do to respect this. The palliative care nurse told us that the service was getting better at providing end of life care to people. They said, "Staff are caring and show empathy to the person and relatives." They told us that they were planning palliative care training for staff.

Good

Is the service responsive?

Our findings

People told us they had opportunity to access the local community and took part in everyday activities such as going to the local shops. There were various activities taking place on the day of our inspection such as games and singing groups. We saw staff engaging people in small groups. One person told us, "There are plenty of activities to do here." Another said, "You never get bored." A relative said, "Something is always happening to get people occupied and they seem to enjoy it." Staff told us people had a choice to participate in any activity they wanted or they could spend quiet time too if they wanted. People were supported to practice their religious beliefs. One person told us that their relative took them to their place of worship when possible and staff reminded them of the day of their worship and supported to get ready early

The manager carried out assessments to identify people's care and support needs. Care plans included information about people's background, social histories and contacts, preferences and interests and how they would like to be supported. Staff told us this helped them understood the person's needs and how to work with them as the person wished. We saw that people's relatives had been involved in planning their care where required and care plans were signed by the person or their representative to indicate their agreement with it.

We saw that care plans were reviewed to reflect people's needs as they changed so that staff knew how to support people. For example, one person's care plan had been updated to reflect the support they required at meal times due to their poor eye sight. We saw that appropriate health and social care professionals had been involved in managing people's changing needs and recommendations made were implemented.

People told us they knew how to make a complaint if they were unhappy. One person told us, "I would go to the manager." The manager told us that they operated an 'open door' policy which meant that people, their relatives and staff were welcomed to express their concern at any time. Relatives we spoke with told us that they knew how to make a complaint but had no reason to make one. A relative told us that "They [staff] sort out things quickly." There had been no complaints recorded within the last year. We saw a copy of the complaints policy and procedure which included how to escalate the issue to other authorities should the complainant want to.

Meetings were held every three months where people could raise any concerns, provide feedback on the service and talk about upcoming events or plans for the service. We saw the minutes of the last meeting held in August 2014 and it reflected discussions related to the day to day running of the service and feedback about menu and activities. There was no action to be implemented.

Satisfaction surveys were sent to relatives of people who used the service in January and April 2014. There were no actions required from the survey. Comments made by relatives included "This home is a home from home. My mum is treated as a friend rather than a resident"; "The staff are really caring. Although dad doesn't always participate in activities, it is great that there is so much offered", and "Always a pleasure to visit mum and other residents. Made to feel welcome, nothing too much trouble. All staff make this a home – not just a residential care home".

Requires Improvement

Is the service well-led?

Our findings

The manager registered with CQC in June 2011 and was aware of her responsibilities in the role. She made notifications to the Care Quality Commission as required and took appropriate action in response to incidents to prevent their recurrence. For example in response to an incident where a person was at risk of harm the manager had reviewed the person's risk assessment and sought specialist advice to ensure their risk management plan was suitable.

Staff told us that the registered manager was available and approachable. Team working was evident and staff told us they felt supported by the management team. One staff member said, "We support each other." Another said, "We work as a team and it's important." Staff meetings were held regularly. We saw minutes from staff meetings where the care and well-being of people living at the service were discussed. Staff also had opportunity to contribute to the running of the service, made suggestions for improvement and shared information. Staff said they felt able to raise concerns with the registered manager and felt listened to.

The local authority commissioning team carried out an annual monitoring visit to the service to check compliance with their standards. The visit involved speaking with people who used the service, reviewing records and observation. There were no outstanding requirements from the last visit.

The registered provider and manager told us they carried out quality audits but these were not recorded. People and the relatives we spoke with told us that the manager communicated with them regularly to update them about the service and to gather feedback from them. They told us that she listened and acted on suggestions made. We discussed this with the manager and she agreed to make records to ensure that the audit system was evidenced.

We recommend that the service seek best practice guidance about systems for monitoring and assessing the quality of service provided.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered manager must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must ensure that information specified in Schedule 3 is available in respect of a person employed for the purpose of carrying out regulated activity. (Regulation 21 (b) Schedule 3 (2)