HC-One Oval Limited

# Fieldway Care Home

## Inspection report

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Tel: 02086483435

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09 January 2019

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## Ratings

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

# Summary of findings

## Overall summary

We inspected the service on 8 and 9 January 2019.

Fieldway is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 68 people. At the time of our inspection 63 people were living in the care home. People living in the care home from now on will be referred to as 'people' throughout this report.

The service continues to have the same registered manager in post who has been in day-to-day charge of the care home since February 2017. A registered manager is a person who has registered with the CQC. Registered managers like registered providers 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.

This was the service's first inspection since we re-registered them in December 2017 under the new provider HC-One Oval Limited. During this inspection, we identified several areas of concern which lead us to issue five breaches of the regulations. We have therefore rated the service Requires Improvement overall, inadequate for the key question, 'Is the service safe?' and requires improvement for the key questions, 'Is the service caring, responsive and well-led?'

The service was rated inadequate in safe because medicines were not always safely managed in the care home. People were supported to take their medicines as they were prescribed, but were not always securely stored. This failure to always follow the relevant National Institute of Clinical Excellence (NICE) guidelines around the safe storage of medicines had put people at unnecessary risk of harm.

Furthermore, the service does not always have enough staff with the right experience to meet people's needs. Although the care home was adequately staffed on both days of our inspection, we received mixed comments from people living in the care home, their relatives, external health care professionals and staff concerned about the lack of experienced staff working who were familiar with the needs, wishes and daily routines of people We also observed several instances of staff not being available in a timely manner when people requested assistance.

People's privacy and dignity were not always respected by staff. Throughout our inspection we observed most staff interacted with people in a kind and compassionate way. However, we saw several instances of staff not respectfully engaging with people they were assisting to eat or entering a person's bedroom without knocking or asking permission to do so.

People did not always receive the right level of personal and health care and support they required to ensure their individual needs and wishes were met.  The mixed feedback we received from people, their

relatives and external health care professionals, as well as our own observations, indicated staff sometimes failed to meet people's basic health and personal care needs by not following their care plan and risk management plan.

The provider had established some good governance systems to assess and monitor the quality and safety of the care and support people received, but we found these were not always implemented. We identified numerous issues the providers governance systems had failed to pick up during our inspection, which included poor management of medicines and staff not always respecting people's privacy and dignity or meeting their needs and wishes. Records the service was required to keep in respect of the people living in the care home were not always appropriately maintained by staff.

You can see what action we told the provider to take in response to all the breaches of the regulations outlined above at the back of the full version of the report.

We discussed all the issues described above with the registered manager and a regional quality assurance director who both confirmed the service was now subject to an internal review being conducted by the provider to look more closely at the problems the service is experiencing, identify the root causes and develop an improvement plan to try and address them. .

Measures to reduce risks posed to people's safety by the environment were in place, but these were not always followed and some equipment had not been kept in a good state of repair. On the first day of our inspection we found several damaged window restrictors on the first floor and chemicals and in an unlocked cupboard. These failures had placed people at unnecessary risk of harm. We discussed these safety issues with the registered manager who agreed to remind all staff about their responsibilities to keep people safe. On the second day of our inspection we saw all the damaged window restrictors had been repaired and doors to rooms where people should not access were kept safely locked when they were not in use.

Staff received most of the training and support they required to meet the needs of the people they supported. However, staff had not received any training in how to prevent or appropriately manage behaviours that could challenge the service. We fed this back to the registered manager who agreed to ensure all staff received suitable training to help them prevent or appropriately manage behaviours considered challenging. We will review at our next inspection whether the action taken by the provider to address this shortfall in staff training has led to improved outcomes for people.

People had opportunities to participate in some meaningful social activities at the home and in the wider community. However, feedback we received from people and their relatives about the quality and choice of the social activities on offer was mixed. We discussed these comments with the registered manager who told us they were actively trying to recruit more activities coordinators to improve the opportunities for people to engage in fulfilling social activities. We will review at our next inspection whether the action taken by the provider has been achieved. We also recommend that the service finds out about the specialist social needs of people living with dementia to develop a more suitable activities programme and dementia awareness training for activities coordinators.

Most people living, visiting or working in the care home, felt the current staff team lacked cohesion and their morale was low.

We found the provider had robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. Appropriate staff recruitment checks took place. The

environment was kept clean and staff demonstrated good awareness of their role and responsibilities in relation to infection control and food hygiene.

As recommended at the service's last inspection we saw easy to read and understand signage was now used to help people living with dementia identify rooms that were important to them. People were supported with their nutritional needs. Staff identified when people required further support with eating and drinking and took appropriate action. The principles of the Mental Capacity Act (MCA) were followed.

People were supported to maintain relationships with their relatives and friends. Staff understood and responded to people's diverse cultural and spiritual needs and wishes. People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives. When people were nearing the end of their life, they received compassionate and supportive care.

People's needs were assessed and planned for with the involvement of the person and/or their relative where required. Each person had an up to date and personalised care plan, which set out how their care and support needs should be met by staff. There was a complaints procedure and action had been taken to learn and improve where this was possible.

People were asked to share their feedback about the service. The registered manager understood their responsibilities and sent us the information they were required to, such as notifications of changes or incidents that affected people they supported.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were supported to take their medicines as they were prescribed, but contrary to recognised best practice, medicines were not always stored safely in the care home.

The care home was adequately staffed on both days of our inspection, but remains over reliant on agency nurses and care workers to cover large numbers of staff vacancies. We found there were not always enough experienced staff to safely meet people's needs.

The provider had robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse.

Appropriate staff recruitment checks took place before staff were permitted to commence working at the care home.

The environment was kept hygienically clean and staff demonstrated good awareness of their role and responsibilities in relation to infection control and food hygiene.

### Is the service effective?

**Requires Improvement**

Some aspects of the service were not effective.

People did not always receive the right level of health care they required to ensure their individual needs and wishes were met.

Staff had the right mix of knowledge and skills to meet the needs and wishes of people they supported, through effective training, supervision and work performance appraisals.

The care home was a comfortable place to live and accessible. As recommended at the service's last inspection we saw signage designed by people living in the home was now used help people living with dementia identify rooms that were important to them.

People were supported with their nutritional needs. Staff identified when people required further support with eating and

drinking and took appropriate action.

People accessed health care services when required.

The principles of the Mental Capacity Act (MCA) were followed.

## Is the service caring?

**Requires Improvement**

Some aspects of the service were not caring.

This was because some people's dignity and privacy were not always respected by everyone who worked at the care home.

People were supported to maintain relationships with their relatives and friends.

Staff understood and responded to people's diverse cultural and spiritual needs and wishes.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

When people were nearing the end of their life, they received compassionate and supportive care.

## Is the service responsive?

**Requires Improvement**

Some aspects of the service were not responsive.

People did not always receive the right level of personal care and support they required to ensure their individual needs and wishes were met.

People had opportunities to participate in some meaningful social activities, but the quality and choice could be improved to make them more suitable for people living with dementia.

People had an up to date and personalised care plan, which set out how their care and support needs should be met by staff.

The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

When people were nearing the end of their life, they received compassionate and supportive care.

## Is the service well-led?

**Requires Improvement**

Some aspects of the service were not well-managed.

Although the provider had governance systems in place, these were not always operated effectively.

People living or working in the care home also felt the staff team lacked cohesion and their morale was low.

The service continued to have a registered manager in post and they understood their responsibilities in relating to sending us notifications about incidents that affected people living in the care home.

People were asked to share their feedback about the service.

# Fieldway Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 comprehensive inspection took place on 8 and 9 January 2019 and was unannounced on the first day. This inspection was brought forward by approximately 12 months in response to the higher than expected number of safeguarding alerts and complaints we had received about this care home throughout 2018. The information shared with the CQC regarding the safeguarding alerts indicated potential concerns about the way this care home was being managed.

The inspection team consisted of one inspector and an expert-by-experience. The expert-by-experience had personal experience of caring for someone living with dementia. Prior to this inspection, we reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also considered information that had been sent to us by other agencies.

During the inspection, we spoke with ten people who lived at the care home and ten visiting relatives. We also spoke to various managers and staff who worked for this provider, including the registered manager, the deputy manager/clinical lead nurse, an area quality director, three registered nurses (all agency staff), five care workers, two wellbeing (i.e. activity) coordinators, the head chef, a laundry assistant, the head of maintenance and a member of business support. In addition, we received written feedback from four relatives and five external health and social care professionals, which included a GP, tissue viability nurse, two commissioners who had a contract with the service and a representative from Merton Seniors Forum. Merton Seniors Forum is an organisation who champion the 'dignity' of older people living in the London Borough of Merton.

Throughout our inspection we observed the way staff interacted with people and performed their roles and responsibilities. We also used the Short Observational Framework for Inspection (SOFI) to observe lunchtime meals being served on both days of our inspection. SOFI is a way of observing care to help us understand

the experience of people who were unable to verbally communicate with us.

We also looked at six people's care records and a range of other written and electronic records that related to the running of the service, such as quality monitoring checks, management of medicines, fire safety, complaints, and staff recruitment, training and supervision.

Inadequate

# Is the service safe?

## Our findings

Some aspects of the way medicines were managed at the service were not safe. We found medicines were not always stored safely. For example, on the first day of our inspection we saw the door to a clinical room and a medicines trolley where medicines were being stored had been left open and unattended with no staff visible in the vicinity. A nurse had left both the doors of a medicines trolley wide open in a corridor, which was frequently used by people and visitors, while they administered medicines to people sitting in the ground floor dining room. A relative also told us they had recently witnessed people living in the home walk past a fully stocked medicines trolley, which had been left unattended by staff with the doors open. This failure to always follow National Institute of Clinical Excellence (NICE) guidelines around the safe storage of medicines and has put people at unnecessary risk of harm.

This represents a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nonetheless, people were supported to take their medicines as they were prescribed. People's care records contained detailed information regarding their medicines and how they needed and preferred these to be administered. Staff received training in the safe management of medicines and their competency to continue doing so safely was routinely assessed by the provider for permanent staff and the relevant nursing agency who supplied the agency nurses.

The home was adequately staffed on both days of our inspection. However, we received mixed comments from people concerned people were not receiving continuity of care and support from permanent members of staff. A relative remarked, "The permanent staff are great, but there seems to be less and less of them these days. It's nothing personal about the agency staff, it's just they don't know what my [family member] needs and what they like to do." External professionals were equally concerned about the service's reliance on mainly agency nurses. Typical feedback we received included, "The recruitment and retention of nurses has proved challenging for this service recently", "Most of the regular nurses have left recently for some reason. There is a real problem with this service holding onto its nursing staff" and "The service is mainly using agency nurses who aren't as good as the permanent staff at following our guidance through and planning our clients care." The registered manager confirmed the service was mainly reliant on agency nursing staff to cover the care home's large number of vacant nurse positions, which stood at eight at the time of our inspection.

We saw staff were not always available when people wanted them and did not always respond in a timely manner to people's requests for assistance. One person told us, "I often have to wait a long time for staff to come when I press my bell for help." We observed call bells were sometimes out of reach of people and were not always being answered by staff in a timely way when they were activated. For example, on one occasion we observed a person had to wait over twenty minutes for staff to respond to their call bell alarm. This person told us they had been waiting for over an hour for staff to help them get out of bed and dressed. On another occasion we witnessed staff actively go looking for another member of staff to help them support someone to get out of bed, despite the member of staff pressing the call bell continuously to indicate the

request for assistance was urgent.

Several staff told us they did not feel there was always enough experienced staff working in the care home who were familiar with people's needs and preferences. One member of staff said, "We've become too reliant on agency nurses lately who don't know the people that live here or how our systems work. Its hard work constantly showing them [agency staff] the ropes." Another member of staff remarked, "It's not the agency's staff's fault to be fair…it's because the nurses are all so new, we feel we have to support them as well as the residents. This means we have to rush to get our work done and tend to focus on just getting people's basic care needs met as best we can."

This represents a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Measures to reduce risks posed to people's safety by the environment were in place. Maintenance records showed the premises and equipment checks were routinely carried out at the care home by suitably qualified professionals. We saw evidence of recent checks of; the gas heating system, water hygiene, portable electrical appliances, electrical installations, fire equipment, alarms, emergency lighting, call bell alarm system, mobile hoists, passenger lifts and hot water temperatures. In addition, the premises were clear of trip and slip hazards which reduced the risk of people falling when moving around the environment.

However, during our tours of the premises we found several damaged window restrictors in two communal areas on the first floor and some chemicals that could be hazardous to a person's health kept in an unlocked cupboard in the first-floor servery, which staff had also left open. We also saw the sluice room door on the ground floor had been left ajar on the first day of our inspection, despite having a keypad device and a sign reminding staff to always keep it locked when it was not in use. These failures put people at unnecessary risk of harm.

We discussed these health and safety issues with the registered manager who agreed to remind all staff about their responsibilities to keep people safe. On the second day of our inspection we saw appropriate action had been taken by the provider to resolve all the issues described above as we had advised. Most people said they felt safe. One person told us, "I feel quite secure here", while a relative remarked, "I'm confident my relative is safe and it's reassuring to go home knowing that." An external health care professional also told us, "The home responds well and in a professional manner to any safeguarding concerns, such as an unexpected pressure sore or bruising." The provider had appropriate arrangements in place to safeguard people from abuse. Staff had been trained in how to safeguard adults at risk and knew how to report any concerns the provider had staff whistle blowing and safeguarding policies and procedures in place to remind staff how to report abuse or neglect.

We looked at documentation where safeguarding alerts had been raised in in the last 12 months. Records showed the provider had taken appropriate action to report any concerns that they were made aware of to the relevant local authority and had cooperated fully in subsequent enquiries and/or investigations. The registered manager told us they worked closely with the London Borough of Merton to manage safeguarding incidents. At the time of our inspection there were two open safeguarding investigations being conducted by the local authority.

Measures were in place to help staff manage risks. Records showed risks such as falls, mobility, nutrition, skin integrity, choking and Percutaneous Endoscopic Gastrostomy feeding (PEG- a tube inserted to the stomach to enable people to receive nutritional support) were identified and the associated risk management plans were in place. During our inspection we witnessed several good examples of two staff

correctly using a mobile hoist and the appropriate sling to safely transfer people from one place to another. Furthermore, it was clear from comments we received from most permanent care staff they knew the potential risks people might encounter and how to manage them.

There were plans in place to help staff manage emergency situations. For example, there was an emergency plan in place in case of fire, adverse weather conditions or damage to the premises. People's care plans contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills and received ongoing fire safety training. Staff knew what to do in the event of an emergency and demonstrated a good understanding of their fire safety roles and responsibilities.

People were protected by the prevention and control of infection. The environment, including communal areas such as toilets and bathrooms, were clean, well maintained and equipped with liquid soap and hand towels to promote good practice in hand hygiene. We saw staff wore personal protective equipment (PPE), particularly when supporting people with their personal care, to reduce the risk of infection. Housekeeping staff were visibly present throughout our inspection keeping the care home clean. All staff had received infection control training. Appropriate systems were also in place to minimise any risks to people's health during food preparation. Staff that worked in the kitchen had received training in food safety so they were aware of the procedures that needed to be followed when preparing and storing food to reduce the risk of people acquiring foodborne illnesses.

The provider had appropriate staff recruitment arrangements in place to check that staff were suitable to support people. When an individual applied to become a member of staff, the provider carried out appropriate checks to ensure staff were of good character and were suitable for their role. This included looking at people's proof of identity, right to work in the UK, employment history, previous work experience, employment and character references, criminal records (Disclosure and Barring Service) checks and registration PIN numbers for qualified nurses. The DBS check provides information on people's background, including any convictions, to help providers make safer recruitment decisions and prevent unsuitable people from working with people in need of support. The provider also routinely carried out DBS checks at three yearly intervals on all long serving staff to ensure their ongoing fitness and suitability for their role.

Requires Improvement

# Is the service effective?

## Our findings

We received several negative comments from people in relation to staff not preventing or managing pressure ulcers properly. A relative told us, "My [family member] has developed severe pressure sores on two separate occasions in the last few months because staff aren't looking after him properly", while an external health care professional remarked, "I believe my client's pressure ulcer was caused by, and ultimately deteriorated, because the clear guidelines we made to help staff meet their skin integrity needs were not always correctly followed by staff." Furthermore, several other relatives gave us examples of how the service had failed to follow their family member's care plan and meet their skin integrity needs. This included staff not repositioning their loved ones who were bed bound at sufficiently regular intervals, which had resulted in people developing pressure ulcers.

This failing represents a breach of regulation 9 of the HSCA (Regulated Activities) Regulations 2014.

The negative points described above notwithstanding, we found people had access to the health care services they required. A GP told us, "Staff are quick to contact our surgery, or call 999, if there is a medical emergency and ensure the rapid involvement of community health care services when required, such as dieticians, the falls clinic and tissue viability nurses." People's care plans set out how staff should be meeting their specific health care needs. The provider ensured people attended regular health care check-ups with a range of community health care professionals, including GPs, tissue viability nurses, speech and language, occupational and physiotherapists, dieticians, dentists, opticians and chiropodists.

The provider ensured staff had the right knowledge and skills to deliver effective care to people they supported. An external health care professional told us, "The permanent staff seem very well-trained." Staff were required to complete a thorough induction, which included shadowing experienced staff. The registered manager told us a more comprehensive induction for agency nurses had recently been introduced to ensure they were familiar with the needs and preferences of the people, their daily routines and the service's operational systems. It was mandatory for all staff to complete dementia awareness training. Permanent staff demonstrated a good understanding of their roles and responsibilities. Staff spoke positively about the training they had received and felt they had undertaken all the training they needed to effectively carry out their roles and responsibilities. One member of staff said, "The training I received since working at the home has been excellent."

However, we found gaps in some staff's knowledge and skills. For example, staff records indicated staff had not received any training in how to prevent or appropriately manage behaviours considered challenging and approximately half the permanent staff team had not recently updated their moving and handling training. This was confirmed by several staff we spoke to. Several staff told us they felt they did not have the necessary knowledge, skills and experience to effectively deal with behaviours that challenge

We fed this back to the registered manager. They told us plans were already in place for all staff to receive up to date moving and handling training by the end of January 2019. They also agreed to ensure staff received appropriate training to help them prevent and managing behaviours considered challenging. We will review

at our next inspection whether the action the provider plans to take to address these staff training issues has led to improved outcomes for people.

Staff had regular opportunities to review and develop their working practices. We saw managers operated a rolling programme of regular one-to-one supervision meetings and annual work performance appraisals for all permanent staff, as well as group meetings with their co-workers. Several staff told us these meetings helped them reflect on their working practices and identify their training needs. The registered manager told us they had recently introduced a rolling programme of regular one-to-one supervision meetings for agency nurses so they could monitor their working practices more closely and identify any gaps in their knowledge and skills. We will review at our next inspection whether the introduction of regular supervision meetings for agency nurses has improved outcomes for people.

The premises met people's needs and were accessible. Most people told us Fieldway Care Home was a comfortable place to live. As recommended at the service's last inspection we saw signage designed by people living in the home was now used throughout the care home to help people living with dementia identify rooms that were important to them. This included pictorial signs in most communal areas, such as lounges, dining rooms, toilets and bathrooms.

Consent was sought before care and support was provided. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 people lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's capacity to make decisions was assessed and best interest decisions were made with the involvement of appropriate people such as relatives and staff. The MCA and associated Deprivation of Liberty Safeguards were applied in the least restrictive way and correctly recorded. For example, people's care plans continued to include guidance for staff regarding consent and an individual's capacity to make important decisions about how they wanted to live their life.

Records showed all staff had received mental capacity and Deprivation of Liberty Safeguards (DoLS) training. It was also clear from comments we received from the registered manager and staff they were knowledgeable about how to work in line with the Mental Capacity Act.

People were supported to eat and drink enough and maintain a balanced diet. We received a few negative comments from people about the standard and choice of food offered at the home, although most people said they were satisfied with the overall quality and choice of the meals provided. Typical feedback included, "The food is generally very good here", "The meals are alright, although they can be a bit samey sometimes" and " Staff do ask my [family member] what they would like to eat at mealtimes." During our inspection we saw staff routinely offered people drinks and the meals served at lunchtime on both days of our inspection looked and smelt appetising. The chef told us, "I always leave something extra like a tray of sandwiches for people to eat after supper just in case people are still hungry."

Risks to nutrition and hydration were assessed and people were offered the support they required. People's care plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. Staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these individuals continued to eat and drink adequate amounts. The chef was aware of people's individual dietary needs and able to cater for people with food allergies or special diets due to their health care needs. We saw catering staff prepare a range of soft, pureed and fortified (high calorie) meals for people with specific nutritional needs.

Requires Improvement

# Is the service caring?

## Our findings

People's privacy and dignity were not always respected by staff. We saw several instances of staff not interacting with people in a particularly dignified or respectful manner. For example, although we saw most staff who were assisting people to eat and drink did so in a kind way, we observed several instances of staff failing to engage respectfully with people they were supporting at mealtimes. On two separate occasions we saw staff assist people to eat their meal in total silence whilst making no attempt to explain what they were doing and what the person was having for their lunch. On another occasion we observed two members of staff who were assisting people to eat their lunch spend most of the mealtime continually turning around and talking to each other, whilst paying very little attention to the two people they were meant to be supporting.

In addition, although we saw most staff did not enter a person's bedroom without seeking the occupant's permission to do so first; we nonetheless witnessed several examples of staff just walking into people's bedrooms without knocking or asking permission to do so. On two other occasions we saw staff who had just entered a person's bedroom without knocking or closing their door behind them make no attempt to acknowledge or engage with the person who occupied the room. A relative told us, "Some staff are very good at knocking on my [family members] door to ask if they can come in, but a lot of the agency staff don't seem to bother very much."

These failures represent a breach of regulation 10 of the HSCA (Regulated Activities) Regulations 2014.

The feedback we received from relatives and external health care professionals about the quality of the care people received at the home was also mixed. Typical comments included, "My patients seem generally happy at the home. The regular staff seem to know the residents well and deliver good care", "I'm very happy with most of the permanent staff who tend to show great patience and compassion to my [family member]. However, some of the agency staff who obviously don't know my [family member] so well, often call her by the wrong name or 'darling', which has provoked a less than positive reaction" and, "Most of the nurses are agency staff and this lack of staff continuity is having a negative impact on the quality and consistency of the care my [family member] receives at the home. The agency staff are understandably not so familiar as the regular staff with my [family members] needs, daily routines and likes."

The negative points outlined above notwithstanding, we observed most staff usually interact with people in a kind and compassionate way during our inspection. We saw most people looked at ease and comfortable in the presence of staff and conversations between them were mostly characterised by warmth and friendliness. The service also has two designated 'Dignity Champions' who are responsible for ensuring staff continue to treat people with the dignity and respect they deserve.

The service ensured people maintained positive relationships with people that were important to them. We observed several people's visiting relatives join their loved one for lunch in a dining room, which the chef told us they encouraged relatives to do. Relatives told us they were not aware of any restrictions on times they could visit their family members

People had their independence promoted. People's care plans included detailed information about their dependency levels and more specifically what they could do for themselves and what help they needed with tasks they could not undertake independently. We saw accessible handrails located throughout the building which enabled people to move freely around the communal areas.

Staff understood and responded to people's diverse cultural and spiritual needs and wishes. An external professional told us, "The hairdressing needs of people with black Afro-Caribbean heritage are met." The chef also gave us some good examples of meals they had prepared for people who had requested to eat food that reflected their cultural heritage and tastes. We saw information about people's spiritual and cultural needs and wishes were included in their care plan. Records indicated staff had received equality and diversity awareness training and permanent staff demonstrated a good understanding of people's cultural heritage and spiritual needs and wishes.

People's care plans contained detailed information about their personal communication styles and preferences and how individuals made choices and decisions about the care and support they received. Staff communicated with people in appropriate and accessible ways. For example, several staff described how they knew from people's facial expressions that they might need a drink or were in pain. The registered manager told us the staff team could speak a variety of different languages, which meant people whose first language was not English, would be able to communicate their needs and wishes to a few staff who spoke and understood their language.

Requires Improvement

# Is the service responsive?

## Our findings

People did not always receive personalised care and support which met their individual needs and wishes. We received mixed comments from people living and visiting the service home.  in relation to staff not always meeting people's personal care needs. needs and wishes. Positive feedback we received included, "The care is really great here…Staff know want I need and like, so I'm happy", "When my [family member's] dementia and health condition worsened the service was excellent at making sure he got the increased support he needed to ensure he continued to be looked after properly" and "In my opinion the residents [my clients] are well looked after by staff who know how to meet their needs."

However, approximately half the people we spoke with expressed dissatisfaction with the care and support provided by the service. Feedback included, "Contrary to instructions in my [family member's] care plan they don't have regular showers", "My [family member] likes to get out of bed in the morning and should be up and dressed by 11am at the very latest, but recently staff don't seem to be coming to help him until 1 or 2 in the afternoon. I've had to ask staff three times lately to get my [family member] because staff we so late coming to help him" and "Staff forgot to give my [family member] their breakfast this morning. They [staff] got it straight away as soon as I told them, but this does sort of thing does seem to be happening more and more these days, which is a very worrying trend."

Several relatives gave us examples of how the service had failed to follow their family member's care plan and meet their basic personal care needs. This included staff not changing soiled pads at frequent enough intervals and not ensuring their relatives were washed or showered every day.

During our inspection we saw several examples of poor staff practice, which resulted in people's care needs and wishes not being properly met. On one occasion, we found an individual who was bed-bound had been left in their bed all morning contrary to their personal care needs and wishes. It was clear from comments we received from two members of staff they were fully aware of this person's preference to be out of bed, dressed and sitting in an armchair in their bedroom by at least 11am every morning. A nurse told us, "This person should have been helped out of bed ages ago, I have no idea why this has not happened." It was also evident from comments we received from several staff we spoke with and our observations staff clearly did not know how to consistently meet the needs of a person who was continuously wandering unaccompanied in the garden without being appropriately dressed for being outside in the winter.

The failings represent a breach of regulation 9 of the HSCA (Regulated Activities) Regulations 2014.

People had opportunities to participate in some meaningful social activities at the home. During our inspection we saw the wellbeing coordinators initiate a few group activities in the communal lounge, including a word game and listening to music, which people and their visitors seemed to enjoy. The weekly activities programme indicated people could choose to participate in a regular arts and craft session, quizzes, musical bingo and a range of board games. In addition, the service had some good links with the wider community. For example, children from a local school and a range of local entertainers and musicians regularly visited the care home to perform concerts and shows.

However, feedback we received from people was about the quality and choice of the social activities on offer at the care home was mixed. Half the comments we received included remarks such as, "There's always seem to be plenty of activities and sing-alongs happening in the main communal areas whenever I visit" and "My [family member] really enjoys the musical recitals they sometimes have here and when the children from the local school come to sing", while others told us, "My [family member] is physically well cared for here. However, I believe they are neglected in respect of their mental stimulation" and "I would like my [family member] to be more engaged with stimulating activities. Residents seem to be bored most of the time."

We discussed this feedback with the registered manager who confirmed the service had two wellbeing coordinator vacancies and acknowledged the range of meaningful social activities people could choose to participate in both in the home and the wider community could be improved. The registered manager told us they were actively trying to recruit more wellbeing coordinators to meet people's social needs and interests. We will review at our next inspection of the service whether the action the provider plans to take resolves this issue.

We also recommend the service finds out about the specialist social needs of people living with dementia, to help the activities coordinators develop more suitable activities programme for people living with dementia.

People were supported to make informed decisions and choices about various aspects of their daily lives. People told us staff supported them to make choices every day about the care and support they received. An external professional said, "People can choose to have a male or female carer." At lunchtime we observed staff show people plated up versions of the two main meal options that were available that day, which enabled people to make an informed decision about what they ate at mealtimes. The chef told us, "If a person does not like the food choices that are available on the menus they can have jacket potatoes, omelette or sandwiches." The deputy manager also gave us a good example of how they had arranged for staff to support a person who had recently moved into the care home to continue having their haircut at a local barber shop as per this individual expressed wish.

People were involved in the care planning process and their preferences about the way they preferred to receive their support was accurately recorded and staff were knowledgeable about these. For example, people's strengths, likes and dislikes, life history and preferences for how they wanted their support to be provided. People, or those with authority to act on their behalf, were involved in routinely reviewing their care plan. As people's needs changed this was reflected in their care plan.

The provider had a complaints procedure which they followed. People said they knew how to make a complaint if they were dissatisfied with the service they received at the care home and were confident that any concerns they might have would be dealt with by the provider. We saw people had been given a copy of the complaints procedure. Appropriate and timely action was taken to investigate complaints and the complaint and outcome of the investigation recorded.

People's preferences and choices regarding their end of life care were recorded in their care plan. A relative told us, "The staff were very empathic and good at talking to my [family member] about the end of life care they wanted to receive." People's families were also involved in helping their loved ones to express their end of life care wishes and ensuring they were met. People were reassured that their pain and other symptoms would be assessed and managed effectively as they approached the end of their life, including having access to support from specialist palliative care professionals. The service worked in close partnership with palliative care professionals from St Raphael's Hospice and local GP's to ensure they always had access to

specialist advice and guidance regarding best end of life care practice.

Requires Improvement

# Is the service well-led?

## Our findings

The provider had systems in place to help managers and senior staff assess and monitor the quality and safety of the care and support people living in home received. For example, at provider level area quality directors routinely visited the care home to carry out regular checks that focused on different aspects of service delivery. Managers based in the care home also regularly undertook their own monitoring checks to make sure staff were working in the right way and meeting people's needs. These audits included checks on care planning and risk assessing, management of medicines, staff recruitment, training and supervision, fire safety, accidents and incidents, infection control and food hygiene, and health and safety.

However, we found these governance systems were not always operated effectively. This was because they had failed to identify and/or address several issues we found during our inspection, such as people's prescribed medicines and Control of Substances Hazardous to Health (COSHH) products were not always being stored safely, window restrictors not being kept in a good state of repair and staff not always meeting people's needs and wishes or respecting their privacy and dignity.

In addition, we found the provider failed to always maintain up to date and complete records of the care and treatment people living in the home received. A relative told us, "We often find staff forget to compete my [family members] fluid intake charts, which they are supposed to keep up to date." During our inspection we identified a significant number of gaps on medicines records and fluid intake charts. In the absence of these records, the provider lacked the ability to effectively challenge staff providing poor care as they did not have documentary evidence to support any concerns they might have about people not receiving their medicines as prescribed or getting enough to drink.

These failings to ensure quality assurance systems were always operated effectively and records staff were required to keep were consistently maintained represent breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post and a management structure with clear lines of responsibilities. The registered manager was supported in the day-to-day operation of the care home by a deputy manager/clinical lead nurse and by regional quality assurance directors at provider level.

However, although most people, their relatives and external health and social care professionals agreed the registered manager and her deputy were ever present in the care home and were approachable; we received mixed comments from a range of people about the way the service was managed. Feedback included, "The registered manager and her deputy run the home very well and are doing their best", "The way the home is managed is the main problem…The managers door is always open, but she constantly fails to act and resolve any of the issues we raise with her, despite the countless meetings we've had with her" and "The management come across as very amenable and receptive to my ideas, but they don't seem to know what is going on in Fieldway right under their noses."

Furthermore, people felt staff morale was low. A relative remarked, "You only have to walk around the home

for it to become obvious that the staff, a lot of which are agency, lack cohesion and team spirit. They just don't appear to be able to work effectively together as one team." Several staff also told us they felt the morale amongst the permanent staff team was low, which many felt was reflected in the high rates of staff turnover. Comments included, "We're using so many agency nurses now that you never know who you're going to be working with next, so it's difficult to build good working relationships with the constantly changing new staff", "Staff morale is very low right now because so many of the experienced permanent staff have left lately" and "It's really hard working here with so many agency staff like me on shift who don't how the care home usually runs. It's definitely seems to have had a negative impact on staff morale."

We discussed our observations and the feedback we received about staffing issues with the management. The registered manager confirmed Fieldway Care Home was currently subject to an urgent review by the provider to try and understand what the root cause of the problem of retaining staff was and to consider the best way to resolve this ongoing issue. We will review at our next inspection whether the action taken by the provider to address this staff retention issue has led to improved outcomes for people living at the care home.

The registered manager understood their responsibilities and sent us the information they were required to such as notifications of changes or incidents that affected people they supported.

The service had an open and inclusive culture and understood the importance of gaining the perspective of people they supported, their relatives and professional representatives. We saw the service had a range of mechanisms in place to obtain people's feedback including, regular group discussions with people and their relatives, and care plan review meetings. The service also had a box and an electronic touch screen system in the reception area to gather people's views.

The provider valued and listened to the views of staff. Staff attended regular team meetings where they could contribute their ideas to improve the home. Records of these meetings indicated discussions routinely took place which kept staff up to date about people's changing care and support needs.

Staff worked in partnership with other agencies. For example, the provider regularly discussed the changing needs or circumstances of people with external health care professionals, local authority commissioners, GP's and nurses. Information was shared appropriately so that people got the support they required from other agencies and staff followed any professional guidance provided. During our inspection we observed several good examples of the registered manager working closely with two external health care professionals to discuss the health care risks two people living in the home might face and how best to prevent or manage those risks.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment service users received at the care home was not always appropriate, met their personal or health care needs, or reflected their expressed wishes. Regulation 9(1)(a)(b)(c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Service users did not always have their privacy respected and were not always treated with dignity by staff. Regulation 10(1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided in a safe way. This was because the provider had failed to ensure medicines were always stored safely. Regulation 12(1)(2)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Governance systems and processes were not always operated effectively to assess, monitor and improve the quality and safety of the service people living at the care home received. The governance systems also failed to ensure |

staff maintained complete and up to date records of all the care and treatment they provided people using the service. Regulation 17(1)(2)(a)(c).

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of experienced staff were not always deployed in the care home to meet people's personal care and treatment needs. Regulation 18(1) |