Roche Healthcare Limited

Fieldhead Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Fieldhead Court took place on 26 February 2018 and was unannounced. This meant the registered provider did not know we were coming.

Fieldhead Court is registered to provide accommodation and personal care for up to 45 people, some of whom are living with dementia. There were 43 people living at the home at the time of our inspection.

Fieldhead Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had previously been inspected during December 2015 and was rated good in the key questions of safe, caring, responsive and well-led. The home was rated as requires improvement in the key question of effective. There were no breaches of regulations identified at the previous inspection.

The home had a registered manager 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.

People told us they felt safe living at Fieldhead Court. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and we observed there were sufficient numbers of staff deployed to meet people's needs. Staff told us they felt supported and we saw evidence staff had received training and ongoing supervision.

Risks to people had been assessed and measures were in place to reduce risks. However, not all risk assessments were up to date and one we looked at had been completed incorrectly so did not accurately reflect the person's level of risk. Some moving and handling plans provided staff with relevant information to safely assist people to move. However, we found one contained conflicting information.

Medicines were administered in a kindly manner. However we found some issues with the recording of topical creams.

There were pockets of malodours within the home which did not dissipate through the day. Some wheelchairs were also odorous.

The building was well maintained and regular safety checks took place. The environment had recently

improved due to some refurbishments.

Our observations showed people were supported to have choice and control of their lives and we observed staff supported people in the least restrictive way possible. However, records relating to people's mental capacity and best interests decision making were inconsistent.

We made a recommendation about the recording of people's mental capacity assessments and best interests decision making.

People received appropriate support in order to have their nutritional and hydration needs met.

People told us staff were caring and we observed staff to be kind and considerate. We observed people's privacy and dignity was respected. People were encouraged to maintain links with their family. People's diverse needs were considered.

Although care records contained personalised information, some care records contained conflicting information. People told us they could make their own choices in relation to their daily lives.

There was a complaints policy in place and people told us they would feel able to complain if the need arose, although no complaints had been made.

Staff told us they felt supported and people and their relatives spoke positively about the registered manager. Regular audits and quality assurance checks took place, although further development was required in order for the registered provider to be fully complaint with the regulations.

We found a breach of regulation in relation to good governance. You can see what action we 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

The service was not always safe.

People told us they felt safe.

Records in relation to some risk assessments, moving and handling plans and the recording of some topical creams were not accurate.

Staff were recruited safely and sufficient numbers of staff were deployed to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The recording of information in relation to people's mental capacity assessments and best interests decision making were inconsistent.

Staff had received induction, training and ongoing support to enable them to provide effective care and support to people, although records of staff induction were not evident.

People's nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and our observations confirmed this.

We observed positive interactions between staff and people who lived at the home which was evident through the mutual respect shown between people and staff.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff demonstrated they knew people's needs well, some care records contained conflicting information. Records did not indicate people had been involved in reviewing and developing their care plans.

A range of activities took place within the home and we observed people engaging and enjoying these.

People told us, and we observed, people were able to make their own choices.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Regular audits and quality checks took place but further work was required in order for the registered provider to be fully compliant with regulations in relation to good governance.

There was a registered manager in post and people and staff told us they had confidence in the registered manager.

The registered provider had up to date policies and procedures in place.

Fieldhead Court

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.

The inspection took place on 26 February 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and we gathered information from local stakeholders, such as the local authority, service commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with seven people who lived at the home, three relatives of people who lived at the home, the registered manager, the deputy manager and clinical lead, five care and support staff, the cook and a member of the domestic team.

We looked at eight people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe. One person said, "The way it's run makes me feel safe. They come straight away when I buzz. I had my tablets this morning. They are always on time." Another person told us, "It's very relaxed and the staff are on the ball. There seems to be enough staff. I can always catch one. They seem to be good at tablets - better than me." A relative told us, "I come every day and see what goes on. I am happy with the care. There's enough staff."

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. A member of staff said, if they suspected any abuse, "I'd definitely report it." Staff also knew how to escalate their concerns and assured us they knew how to whistle blow if they felt any concerns were not listened to. This showed staff would take appropriate action if they had concerns anyone was at risk of abuse or harm. Furthermore, the registered manager told us people were protected from discrimination because staff had received equality and diversity training.

Risk assessments had been undertaken for a range of risks, such as those associated with falls, diet and nutrition and skin integrity. Some recognised risk assessment tools were used to help determine risks. However, we found not all risk assessments were up to date and one we looked at contained contradictory information regarding a person's mobility needs. A falls risk assessment we reviewed indicated a person's score was 11, which would place them at low risk. However, the person had been scored incorrectly and their actual score should have been 13, which would place them at medium risk. This meant some risks had not been adequately assessed. We shared this with the registered manager who agreed to take action to rectify this.

We saw examples of good moving and handling plans, which provided staff with information to safely help people to move. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely. However, we also found not all mobilising care plans were up to date and one contained contradictory information. For example, a person's plan stated the person was 'Totally dependent, requires a hoist,' in one section and, 'May need standing hoist,' in another section, without offering further guidance as to if or when a standing hoist might be safe to use. This meant not all mobilising care plans were an accurate record of the person's care needs.

The above demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because records in respect of each person were not always accurate.

Equipment was used to help keep some people safe, such as specific chairs or bed rails. The associated risks were assessed and consideration was given as to whether the equipment was necessary to keep the person safe. One person was unsafe to sit in a standard chair or wheelchair. Therefore the risks had been assessed and the person used a specific chair to meet their needs. This helped to ensure the person's safety.

'Falls huddle' meetings were held every morning, during which staff discussed issues relating to falls. The

registered manager told us, "It's about getting the whole team to watch out for people at risk." This meant, despite some records being inconsistent, the registered manager took a proactive approach to help to reduce risks associated with falling.

Some people had been admitted to the home with pressure sores. We looked and found wound management was safe and appropriate. Records showed appropriate washing and dressing changes. However, we noted a person's care record which indicated the person should be assisted to reposition every two hours did not have a chart or record of this happening, despite this person having a pressure sore. We were assured the person was receiving the required care but the records could not confirm this. This further demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because records of care provision were not always accurate and complete.

We looked at how medicines were administered and managed. Medicines were administered by nurses or senior carers who had received specific training. Medicines were administered in a very kind and caring manner. The staff member administering medicines knew people well. People were asked how they were feeling and given the time they needed to take their medicines.

People's medicines were stored in locked cabinets in their own rooms. The registered nurse told us this reduced the risk of administering the wrong medicine to a person.

The recording of the application of prescribed creams was not effective. Some records indicated creams should be applied, 'As directed.' However, there were no further instructions to advise staff when and where the creams should be applied. No body maps were used to indicate to staff where about on the body to apply the cream. This meant there was risk creams were not applied correctly.

The application of topical creams was not effectively recorded. One person's topical medicine administration chart (TMAR), which was used for recording the application of topical creams, indicated a cream should be applied twice daily. However, records showed during the month of February, the cream had been applied only once daily on 6 days and had not been applied at all on 7 days. Another person's TMAR indicated their cream should be applied twice daily and records showed the cream was applied only once a day on six days in February and the cream was not applied on seven days. The person told us care staff applied the creams and staff told us they applied the creams. However, incomplete records meant it was not possible to determine if and when creams were applied. We highlighted this concern to the clinical lead and recommended they take appropriate action to rectify this.

The above further demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because accurate records of care provision were not completed and maintained.

Some people were prescribed PRN, or 'as required' medicines, such as paracetamol. Although we observed staff ask people whether they would like their PRN medicines, and staff displayed good knowledge of people's needs, PRN protocols were not in place for some people. Having PRN protocols would help to ensure these medicines were administered appropriately and at safe intervals. The clinical lead was aware of this and told us they were introducing protocols for all PRN medicines administered at the home. There was an effective reconciliation system in place to ensure all PRN medicines were accounted for appropriately.

We did not observe any behaviour that people might find challenging. However, we observed staff used very effective distraction techniques when people appeared to be confused. Staff validated people's views and

feelings but then appropriately and effectively distracted people. This demonstrated staff were aware how to provide effective care to people living with signs of dementia and this helped to keep people safe.

Regular safety checks took place throughout the home in relation to, for example, hot and cold water temperatures, call bell systems and safety of equipment such as bed rails and wheelchairs. The fire safety policy had been updated in September 2017 and records showed fire systems such as alarms and emergency lights were checked regularly. Tests such as gas safety and electrical portable appliances had been completed. Lifting equipment had been tested and examined. This helped to ensure the safety of premises and equipment.

The registered manager told us lessons were learned both at a local and national level, either from incidents within the home or incidents nationally and the registered provider would share learning with the registered manager. Accidents and incidents were analysed monthly and records showed actions were taken following accidents and incidents, such as first aid being applied or increased observations taking place and risk assessments being updated.

The registered manager used a dependency tool to help determine the numbers of staff required and rotas showed the number of staff identified as being required were deployed. Staff told us they felt there were sufficient staffing levels to keep people safe. A member of staff said, "There are enough carers, yes. We don't have any vacancies and we're fully staffed. I think that's very rare in homes, but that's a good thing here."

There were mixed views from people and relatives regarding staffing levels. Most people told us they felt there were enough staff. However, one person said, "They are sometimes short and things slow down," and another person agreed, "They are under pressure sometimes." One relative told us they felt their family member had to wait too long for assistance at times. Throughout our inspection, we observed people's needs being met in a timely manner.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

People told us staff wore personal protective equipment (PPE) when providing personal care and all of the staff we asked told us they had access to adequate supplies. This helped to prevent and control the risk of the spread of infection.

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Requires Improvement

Is the service effective?

Our findings

People told us they felt staff were effective. One person told us this was because, "They always come when I buzz." Another person told us, "They got the doctor for my poor eye." A further person told us, "They seem to know what they're doing." People were complimentary about the food at the home, with one person saying, "The meals are brilliant."

The registered manager told us, and records showed, observations of staff practice took place, for example to ensure staff were following appropriate moving and handling procedures. This helped to ensure staff maintained the necessary skills to provide effective care.

The registered manager invested in staff. This was evident through the further, advanced, training opportunities which had been sourced for some staff who showed an aptitude and interest in nursing, with a view to those staff being able to later train to become nurses. Other staff received advanced training in health and social care management qualifications. This further helped to develop staff to enable them to provide effective care and support.

The staff we asked told us they received an induction into their role and this included shadowing more experienced members of staff. However, with the exception of nursing staff who completed a thorough induction booklet, the records we reviewed did not evidence staff induction. We raised this with the registered manager and they told us they would consider introducing a similar induction booklet for care workers.

Records showed staff received training in areas such as safeguarding, moving and handling, health and safety, fire safety, first aid at work and dementia care. This helped to ensure staff had the necessary skills to perform their roles effectively.

Staff told us they received regular supervision from the registered manager and we saw records of these. A staff member told us, "Some of the training is on-line but then you get observed so you know if you're doing it properly." We were told, "It's better now because you're observed in a real life situation instead of just doing learning at head office." Another member of staff said, "They're really on the ball here with training." This showed staff felt their training was effective.

All of the staff we asked told us they felt supported in their roles. Records showed staff were praised and thanked for their hard work. One staff member told us, "We all work as a team and all help each other out. I always ask. If I didn't know how to do something, I'd ask." Staff told us they would feel able to request additional training if they felt this was required and they felt assured this would be provided.

The registered manager and clinical lead were contributing towards developing best practice in the area of health and social care. The registered manager had enrolled on an 'experienced managers' course, which was a 12 month learning programme and they demonstrated commitment to continual professional development. The clinical lead also showed this commitment, contributing towards an improvement

academy regarding safety projects. An event was planned to be held at the home in line with a, 'To dip or not to dip' project, which was aimed at highlighting a person centred approach to improving the management of urinary tract infections. This demonstrated continual learning and good knowledge of best practice.

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

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

In relation to the use of a specific chair, which restricted a person's movement, one person's record stated, '[Name] doesn't have capacity therefore a decision has been made in [Name]'s best interest to ensure safety is maintained.' However, there was no mental capacity assessment to indicate the person's capacity had been assessed in order determine whether they had capacity to make that decision. A decision may only lawfully be made in the person's best interests if they lack the capacity to make that decision for themselves.

Furthermore, we saw a person who had bed rails attached to their bed (to stop them from falling out) had not consented to this and there were no records to indicate this decision had been made in their best interests. A further mental capacity assessment had been completed for another person but the assessment did not indicate what decision the assessment related to. In line with the MCA, mental capacity assessments must be decision specific.

We saw some good examples of least restrictive practice being applied. For example, one person did not like bed rails. They had made this decision and a statement in their care record indicated, '[Name] requests not to have bedrails up at night or when in bed. Call system to hand.' This showed another, least restrictive, option had been used to help keep the person safe.

Although there were good examples which showed the MCA was being applied in principle, we recommend the registered manager reviews their records to ensure decision specific mental capacity assessments and best interests decisions, if appropriate, are completed and recorded.

Care records contained formal consent forms which some people, or their relatives, had signed. We noted some relatives had signed to indicate consent when it was not clear whether they had the power to do so. The registered manager demonstrated to us they understood only people with the appropriate Power of Attorney could consent to care on behalf of other people and advised sometimes family members signed consent forms if people were able to give their consent, but were physically unable to sign the form. The registered manager agreed they would ensure this was made clear on the document.

We looked at how people's nutritional and hydration needs were met. We saw menus were displayed on the dining tables and these showed choices at breakfast time of a cooked breakfast or a variety of cold options. There were two main meal options at lunch time and a variety of sandwiches, soup and snacks at tea time.

People were able to make choices from the menus and we also observed people being provided with alternatives to the menu when requested.

Staff knew the support people required to eat their meals because this information was contained in people's care plans. We saw records documented people's dietary needs and staff demonstrated they were aware of these. Kitchen staff were aware of people's dietary needs and this information was displayed in the kitchen, for example in relation to the safe consistency of food for people. We asked some care staff about the assistance people required to eat their meals. Staff were clear on the assistance people required and we observed this in practice.

We observed a meal-time experience. Tables were pleasantly set with table-clothes, napkins, condiments, juices, flowers and menus. Some equipment was used to assist people to eat their meals and retain their independence at meal-times. We saw plate guards in use, which meant people could independently eat their meal without the food falling off the edge of their plate. One person did not wish to choose anything from the menu but made a very specific request for their meal. This request was accommodated promptly. We heard staff asking people whether they would like more food, before taking plates away. Kitchen staff were visible during mealtimes and could be heard asking people whether they enjoyed their meals. This showed people received support to meet their nutritional and hydration needs.

Where people had been prescribed supplements to their diet, these were not consistently recorded. Some additional sheets were being used, as well as the medicine administration records and this meant there was duplication of information and some of the additional sheets were not completed. Staff assured us, and people confirmed, they took their supplements but the records were not accurate and complete.

We noted records did not always accurately reflect people's intake. For example, one person had lost weight and their food intake was being monitored. However, records did not indicate snacks the person had eaten and only actual meals were recorded. This meant records had not been maintained of the person's dietary intake. The registered manager assured us they would take immediate action to rectify this.

We looked at the design and layout of the building. The reception area of the home was large, bright and airy. Displayed was a board with photographs and names of staff. This helped to ensure staff could be identified. Recent refurbishments had been ongoing at the home. The dining room and lounge area had been recently decorated. There was a homely feel to the home with fresh flowers displayed and pictures on walls.

We noted there was limited signage, and no signage upstairs to help people to navigate. Displaying signage and information in appropriate formats can help people, and particularly people living with dementia, to navigate more effectively.

On the first day of our inspection we observed a handover meeting between the night staff and day staff at the home. Relevant information was shared between staff, which helped to ensure people received continuity of care. Information such as any referrals to health care professionals, and the outcome, was shared. We observed the team leader then gave clear direction to staff. Team-work was evident. A staff member told us, "Handovers are critical so we can make sure we all know what we're doing. We have to make sure people are safe and we all know where we're at." This meant an effective system of communication was in place to facilitate team-working at the home.

Records showed people had access to health care professionals such as chiropodists, GPs, nurses and physiotherapists, in order to meet their wider health care needs.

Good

Is the service caring?

Our findings

We asked people whether staff were caring and people confirmed this. One person told us, "I wouldn't want to do it [provide personal care], but they [staff] tell us that's what they're here for. They're very good." Another person said, "I can't praise them enough, no complaints, they look after you. I like being in my room and I am thankful for all they do for me." A relative told us, "All the staff are kind. I have not seen anything wrong. They treat [my relative] well."

A staff member told us, "I love it here. I couldn't be here if I didn't like it. I like this home. We give people choice." Another member of staff said, "We all care for the residents but we care for each other as well." Staff were motivated to provide good care. One staff member told us, "I wanted to look after vulnerable adults. I treat them how I'd treat my parents or grandparents." This helped to create the caring, respectful environment which was evident.

We observed a mutual respect between people who lived at the home and staff. A person we spoke with confirmed this and told us, "I treat them [staff] with respect and they talk to me with respect."

We saw staff assisting people to move and, as they did so, staff used supportive tones and helped to put people at ease. People responded well to this and told us they felt assured and safe.

When a person appeared upset and confused, a member of staff went into the person's room to provide comfort and reassurance. Throughout our inspection we observed staff interacting with people in a kind, caring and friendly manner. Staff knew people well and spoke about people's families, interests and life histories.

Staff demonstrated they understood the importance of effective communication. We heard a care worker assist a person to set up their television in their room. The care worker asked the person if they would like sub-titles setting up. This showed they were mindful to ensure the person's sensory needs were considered.

The registered provider employed staff from a range of different backgrounds and staff had received training in relation to equality and diversity. This helped to create an inclusive environment. A diversity and quality statement was included in service user guides and this assured people they would be treated with respect and that specific needs, such as religious needs, would be respected. A religious leader visited the home regularly.

The registered manager showed they understood when advocacy services would be appropriate and they knew how to access advocacy if this was required. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

People were able to maintain contact with those important to them. We observed relatives were able to sit with their family members at mealtime. This meant families could take meals together.

We observed people's privacy was respected. Notices were hung on doors which staff used to indicate 'care in progress – do not enter.' A member of staff told us these signs were useful in ensuring no-one entered the room if someone was being assisted with personal care. This helped to ensure people's privacy was maintained.

The staff we spoke with indicated they knew how to protect people's dignity and privacy. One staff member told us, when they were providing personal care, "I pull the curtains on and make sure the door's closed. I keep asking the person if they're okay and keep them covered up as much as possible. I keep asking permission." This showed the staff member understood how to maintain a person's privacy.

People's relationship needs had been considered. There was a double room in the home and steps had been taken to ensure these arrangements were suitable for the occupants of the room. People's care records included details such as how they liked to express themselves, for example through their attire. We observed one person's care record indicated it was important to them that they, 'Look smart and well presented.' They were dressed very smartly. This showed the person's needs, in terms of how they wanted to express themselves, were considered.

Requires Improvement

Is the service responsive?

Our findings

People told us they could make their own choices. One person said, "Yes, I can get up when I like." Other people told us they chose whether they wished to partake in the varied activities on offer at the home.

We looked at eight people's care records. These contained information relating to people's individual needs, such as those in relation to communication, continence, personal hygiene and eating and drinking. Information relating to people's preferences were included in care plans. Records included a document called, 'Map of the life of [Name]' and this contained information relating to the person's family history, childhood memories, previous employment, hobbies and interests. Including information such as this in people's care records enables staff to provide care which is person centred.

When we spoke with staff, they indicated to us they were aware of the content of people's care records and all of the staff we asked told us they had access to care plans and they read them. Our observations indicated staff knew people well.

The registered manager told us, and records showed, care plans were evaluated monthly. We were told people were involved in these evaluations and reviews, although records did not verify this.

Some care records contained conflicting information. For example we found a record stated a person should have, 'Regular stands from the chair to relieve pressure.' However the plan then stated the person was hoisted at all times. One person's sleeping care record stated, 'Door closed, small light on.' However, the person's room risk assessment stated, 'Door left open at all times. The only time [they] would like it closed is when carers are delivering personal care.' We also found conflicting information relating to the type of mattress and mattress settings people required. One person's risk assessment indicated they required an air flow mattress but their care plan indicated they required a foam mattress. We shared this with the registered manager, who assured us people were sleeping on the correct mattress and agreed to correct the records to reflect this.

The above examples further demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because records relating to the care and treatment of each person were not accurate.

There was an activities coordinator at the home, who clearly knew people well and was very engaging. Activities such as music, exercises, floor games, ball games, quizzes, bingo, arts and crafts took place. We observed some activities taking place. We found the activities coordinator used the structured activities effectively to generate conversation and engage with people. People responded well to this and there was a pleasant, upbeat atmosphere.

Some people chose to stay in their own rooms. Staff told us the activities coordinator would also sit with people and chat or read with them. We heard the activities coordinator reading a letter to a person in their own room. The person was given time to absorb the information and this was done in a very kind, caring

manner and the person clearly appreciated this.

A person told us, "I'm happy to be in my room with my own TV, staff come and go all the time, they are very kind and considerate. I have no complaints."

We observed when activities were taking place, the coordinator ensured people who had mobility needs were encouraged to join in and they were assisted to the area where the activities were taking place, if they so wished. This created an inclusive environment and atmosphere.

All of the staff we asked told us people could make their own choices such as when to rise or retire to bed, when to bath or shower, what to eat, what to wear. We heard people making choices throughout our inspection, such as what to eat, where to sit, which activities to do. Staff could be heard saying phrases such as, "Where would you like to sit?" and, "What would you like to drink?" and "Shall I help you with that?" This showed people were able to make their own choices.

We looked at how information was provided and shared with people. The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand and any communication support they need. Although the registered manager was not aware of the Accessible Information Standard, we saw information had been provided in alternative formats. For example, some information was pictorial and we saw care records contained information relating to people's specific communication needs. Where people had hearing impairments, this was recorded in their care records and the staff we spoke with were aware of people's communication needs. This showed consideration was given to people's individual needs in relation to communication methods.

People's rooms were personalised and we could see items of sentimental value were displayed, such as family photographs and mementoes. This helped to create a homely environment for people and meant they could personalise their own space.

There was a complaints policy in place and, although no complaints had been received, guides were placed in people's rooms which outlined how complaints or suggestions could be made. People told us they would feel able to complain if they felt the need.

One of the care plans we looked at contained specific person-centred information relating to end of life wishes. However, some care plans did not contain information relating to end of life wishes. The registered manager was aware of this and was working towards respectfully gathering this information to enable person centred care to be provided at the end of a person's life. The staff we spoke with understood, and were able to outline, what good end of life care looked like.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission (CQC) to manage the home since October 2010.

One member of staff said of the registered manager, "She's stern. A good boss. She helps you." All the staff we spoke with told us they felt supported. One member of staff said, "She pushes people [staff] to be the best they can be." Another member of staff said, "She's good at her job,' referring to the registered manager.

People knew who the registered manager was. One person told us, "The manager is lovely. She comes in and sees me in the lounge." A relative told us, "The manager's always here and available. We have meetings from time to time so we can air our views."

During our inspection we found multiple examples of inaccurate, conflicting or incomplete records. For example, we found the application of topical creams were not accurately recorded, the support people were given to reposition when they were at risk of skin break-down was not recorded, records relating to mental capacity assessments and decisions made in people's best interests were inconsistent, some food intake records did not accurately reflect people's intake, prescribed supplements were not accurately recorded and we found conflicting information in some care records and risk assessments. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because records relating to the care and treatment of each person were not accurate, complete and contemporaneous.

Staff told us, and records confirmed, meetings were held regularly with different groups of staff. A staff member told us, "She [the registered manager] asks if there's anything we want to bring to the meetings. We can always raise things." Records of staff meetings showed appropriate items such as recording information, moving and handling and safe administration of medicines were discussed. Records showed the registered manager had prompted staff to read people's moving and handling plans because these had been updated and were more comprehensive. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Records showed residents' meeting took place, although one had not yet taken place in 2018. Items such as snacks, activities and special events had been discussed at previous meetings.

The registered manager told us they felt supported by their peers, the registered provider and stakeholders such as the local authority. They told us they felt they had access to the resources they required in order to provide safe, effective care for people living at Fieldhead Court. The registered manager and clinical lead were effective role models and they demonstrated a commitment to continuous personal and professional development. This was evident through their knowledge and contribution towards best practice.

Regular audits took place in relation to the environment and equipment such as mattresses and wheelchairs. We found these audits were effective in that, where areas for improvement were identified,

action was taken. Audits resulted in equipment being updated, replaced or maintained. However, the audits had not identified or resulted in action in relation to the odorous wheelchairs we highlighted.

Regular medicines audits took place and we saw, following a recent audit, some action plans had been developed which had resulted in improved practice.

A monthly audit report was completed by the registered manager and submitted to the registered provider. This included details in relation to people's weight, falls analysis, referrals made to health care professionals and people's level of dependency. This meant the registered provider had an overview of the service.

Care plan audits took place regularly and these checked whether all sections of care plans were completed appropriately. We found, however, these did not always identify areas for improvement, such as those required in relation to assessing people's mental capacity and conflicting information we found in some care records. This meant further development of audits were required.

Quality audits were also undertaken by the registered provider. Monthly quality and compliance monitoring visits took place. These looked at, for example, the environment, specific events or incidents, premises and equipment and involved speaking with people and staff. We noted any actions were reviewed from the previous visit and these had resulted in improvements. Actions such as improved lighting and refurbishments had taken place.

There were links between some community organisations and the home. For example, religious leaders visited the home regularly and students from a local college undertook placements at the home. This showed the registered provider engaged with the local community.

The registered provider had a range of up to date policies in place such as in relation to the administration of medicines, fire safety, safeguarding and whistle blowing. Having up to date policies helps to ensure staff are following current, up to date guidelines.

The registered manager was responsive to our inspection and was keen to further develop and improve the home. This was evident as they took immediate actions to address some of the issues we identified.

The registered manager was aware of the registered provider's vision and values of respect, openness, care, honesty and empathy. These were clearly displayed in the registered manager's office.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

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 17 HSCA RA Regulations 2014 Good governance Records relating to the care and treatment of each person were not always accurate, complete and contemporaneous.