Bupa Care Homes Limited

Fieldway Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Fieldway Care Home provides nursing and personal care for up to 68 older people. The service has 37 designated beds for people with nursing needs and 31 beds for people who require residential care. At the time of our inspection there were 66 people residing at the home, approximately half of whom were living with dementia.

At the last Care Quality Commission (CQC) inspection in May 2015, the overall rating for this service was 'Good'. Since that inspection Fieldway Care Home has been reregistered by the CQC in February 2017 to another Bupa sub-company. Consequently, this inspection represents the service's inaugural inspection and rating under the new provider, although most staff, processes and systems and people using the service continued to be the same. We found this newly registered service met the regulations and fundamental standards and we have rated them 'Good' overall.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We have made a recommendation about the home's environment and design not being as dementia 'friendly' as it could be. Although we saw there were some signs up in the home to help people identify toilets and bathrooms, most bedroom doors lacked any visual clues in order to make the room more recognisable to people. We also saw communal areas such as hallways and bedroom doors, which had recently been redecorated, had been painted in similar colours. This lack of attention to the environment where people with dementia were cared for could lead to people becoming disorientated to place.

People and their relatives told us they were happy with the care the service provided. We saw staff looked after people in a way which was kind and caring. Staff had built caring and friendly relationships with people and their relatives. Our discussions with people living in the home, their relatives and community health care professionals supported this.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. The provider assessed and managed risks to people's safety in a way that considered their individual needs. Recruitment procedures were designed to prevent people from being cared for by unsuitable staff. There were enough staff to keep people safe. The premises and equipment were safe for people to use because managers and staff routinely carried out health and safety checks. Medicines were managed safely and people received them as prescribed.

Staff received appropriate training and support to ensure they had the knowledge and skills needed to perform their roles effectively. People were supported to eat and drink enough to meet their dietary needs and preferences. They also received the support they needed to stay healthy and to access healthcare

services.

Staff were caring and treated people with dignity and respect and ensured people's privacy was maintained particularly when being supported with their personal care needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received personalised support that was responsive to their individual needs. 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. This meant people were supported by staff who knew them well and understood their needs, preferences and interests. Staff encouraged people to actively participate in meaningful leisure activities that reflected their social interests and to maintain relationships with people that mattered to them.

The managers provided good leadership and led by example. People felt comfortable raising any issues they might have about the home with managers and staff. The service had arrangements in place to deal with people's concerns and complaints appropriately. The provider also routinely gathered feedback from people living in the home, their relatives and staff. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were enough staff to meet people's needs. The provider had completed checks to ensure as far as possible only suitable people were employed.

Staff knew how to safeguard people at risk. They ensured people received their medicines as prescribed.

There were assessments in place to ensure people were kept as safe as possible. Accidents and incidents were recorded so any trends could be identified to help prevent reoccurrences.

Is the service effective?

Good

The service was effective. Staff had completed their required training or received adequate support from their line manager to ensure they had the right knowledge and skills to effectively perform their roles.

The registered manager and staff were knowledgeable about and adhered to the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access healthcare services.

Is the service caring?

Good

The service was caring. People said staff were kind, caring and respectful.

Staff were thoughtful and considerate when delivering care to people. They ensured people's right to privacy and to be treated with dignity was maintained, particularly when receiving personal care.

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

Is the service responsive?

Good

The service was responsive. People were involved in discussions and decisions about their care and support needs.

People had an up to date, personalised care plan, which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and interests.

Improvements had been made to the activities programme and people were actively encouraged to participate in social activities that were meaningful and reflected their social interests.

People knew how to make a complaint if they were dissatisfied with the service they received. The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

Is the service well-led?

Good

The service was well-led. Managers provided good leadership and led by example.

The provider routinely gathered feedback from people living in the home, their relatives and staff. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

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

This was an unannounced comprehensive inspection which took place on 28 and 30 March 2017.

The inspection was carried out by an inspector 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. This expert-by-experience had experience of caring for a family member living with dementia.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We also reviewed the provider information return (PIR). The PIR is a document we ask providers to submit before our inspection about how they are meeting the requirements of the five key questions and what improvements they intend to make.

During this two-day inspection we spoke with 18 people who lived at the home, 12 visiting relatives and a London Ambulance Service driver. We also talked to various members of the services management and staff team which included, the registered manager, regional director, regional manager, deputy manager, the head of housekeeping, the clinical lead nurse, three other registered nurses, five care workers, the lead activities coordinator and a laundry assistant. We observed the way staff interacted with people living in the home and performed their duties. During lunch we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included seven people's care plans, six staff files and a range of other documents that related to the overall management of the service, such as quality assurance audits, medicines administration sheets, complaints records, and accidents and incident reports.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person said, "I feel safe here because I'm well cared for by the staff." Another person's relative remarked, "The dedicated staff who work here keep my [family member] safe."

The provider had robust systems in place to identify, report and act on signs or allegations of abuse. Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. One member of staff told us, "I've never seen anyone abusing the people we look after here, but if I did I wouldn't hesitate to tell the nurse in charge, and if I wasn't happy with their response I would go straight to the area manager or the Care Quality Commission." We looked at documentation where there had been safeguarding concerns about people and saw the provider had taken appropriate action, which they followed up to ensure people, remained safe and to prevent reoccurrence.

Measures were in place to reduce identified risks to people's health, safety and welfare. Managers assessed and reviewed risks to people due to their specific health care needs. They had put in place risk management plans for staff to follow to reduce these risks and keep people safe whilst allowing them as much freedom as possible. This included eating and drinking, mobility and safe transfer using a hoist and skin care. Our observations and discussions showed staff understood the risks people faced and took action to minimise them. For example, we saw staff followed individual guidance when supporting people with swallowing difficulties to eat their meals and minimising the risk of pressure sores developing for people who were bed bound.

Managers and senior nurses followed up the occurrence of any accidents or incidents involving people living in the home and developed action plans to help prevent them from happening again. Examples included reviewing people's risk assessments and reviewing guidelines for staff about how to support people safely. Staff gave us several examples of situations where they had used incident reporting to identify trends and patterns to develop an action plan which had resulted in a significant decrease in the number of incidents related to people's behaviour that challenged the service.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency plans to help staff deal with such emergencies quickly. For example, a personal emergency evacuation plan (PEEP) had been developed for each person who used the service, which provided guidance for staff if people needed to be evacuated from the premises in the event of an emergency. Staff demonstrated a good understanding of their fire safety role and responsibility and told us they received on-going fire safety training.

The environment was well maintained which contributed to people's safety. Maintenance records showed service and equipment checks were regularly carried out at the home by suitably qualified professionals in relation to the home's fire extinguishers, fire alarms, emergency lighting, portable electrical equipment, water hygiene, and gas and heating systems. We observed the environment was kept free of obstacles and

hazards which enabled people to move safely and freely around the home and garden. We saw chemicals and substances hazardous to health were safely stored in locked cupboards when they were not in use.

The building was also kept clean and tidy. The toilets and bathrooms were well maintained, and equipped with liquid soap and hand towels to promote good hygiene. We looked at the cleaning rotas, which had designated daily, weekly and monthly duties. Managers and senior staff carried out spot checks and audits to check that the rota was adhered to and ensure that the standard of cleanliness remained high. Appropriate systems were in place to minimise any risks to people's health during food preparation, for example the use of colour coded chopping boards and the daily checking of fridge and freezer temperatures. This showed that there were measures in place to help protect people from the risk of infection due to an unhygienic environment.

The provider's recruitment process helped protect people from the risk of employing unsuitable staff. The provider maintained recruitment procedures that enabled them to check the suitability and fitness of staff they employed to support people living in the home. Records showed the provider carried out criminal records checks at three yearly intervals on all existing staff, to assess their on-going suitability.

There were enough staff to support people. We received mixed comments from people and their relatives about staffing levels in the home, although most felt staff shortages were historical which the registered manager had now addressed. Typical feedback included, "I visited a few times last year when the home was really short staffed. I think people rang in sick at the last minute and the home couldn't get anyone to cover", "In the past I would worry that there were not always enough carers to look after all the people that lived at the home, especially at weekends, but to be fair to the manager staffing levels have definitely improved recently" and "There seems to be a lot more staff about at the moment. My [family member] has had falls in the past, but now they make sure someone is with them all the time so they're safe."

When we arrived at the home on the first day of our inspection we saw there were two nurses and 14 care workers on duty to look after 66 people. The registered manager confirmed the home had its full complement of care, catering and domestic staff on duty on that day shift. Rotas confirmed these levels were met. Throughout our inspection we saw staff were visible in communal areas, which meant people could alert staff whenever they needed them. We saw numerous examples of staff attending immediately to people's requests for a drink or assistance to stand. People told us staff were quick to respond when they used their call bells.

The registered manager told us they looked at rotas daily to assess whether extra staff were needed, for example if there were activities taking place outside the home that required extra staff support. We saw the staff rota for the service was planned in advance and took account of the level of care and support people required in the home. Additional staff were arranged when needed, for example, when people attended hospital appointments. The registered manager told us that in response to concerns raised by people about staff ratios in the home during 2016 they had introduced a new 'twilight shift' between 6am and 3pm which meant additional carers are on duty to cover this traditionally busy period of the day. Furthermore, back to work interviews have been introduced for staff who take sick leave to help manage absenteeism related to sickness.

There were robust systems in place to ensure medicines were managed safely. One person told us, "They [staff] wait and check to see I've taken my medicines." Another person said, "I get my medicines on time." People's care plans contained detailed information regarding their medicines and how they needed and preferred these to be administered. We looked at medicines administration records (MARs) which should be completed by staff each time medicines were given. There were no gaps or omissions which indicated

people received their medicines as prescribed. Our checks of stocks and balances of people's medicines confirmed these had been given as indicated on people's MAR sheets. Staff received training in the safe management of medicines and their competency to handle medicines safely was assessed annually.

Good

Is the service effective?

Our findings

People and their relatives told us staff were good at their jobs. One person said, "The staff must have the right training because they all seem to know what they're doing." Another person's relative told us, "I think all the staff who work here are really well trained and good at what they do."

New staff received a thorough induction that included shadowing experienced members of staff. Systems were in place to ensure staff stayed up to date with training considered mandatory by the provider. Records indicated staff had recently completed training in dementia awareness, moving and handling, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards, fire safety, food hygiene, equality and diversity, first aid, and prevention and control of infection.

Staff spoke positively about the training they had received. One member of staff told us, "There's plenty of training and it's always on-going." Another member of staff said, "I think one of the best things about working for a big organisation like Bupa is all the training they provide you." Managers monitored staff training and arranged refresher training as and when required so staff's knowledge and skills remained up to date. Where people had specific needs, staff received specialist training to enable them to properly meet those needs. For example, staff who supported people with urinary catheters had been suitably trained to perform this aspect of their role.

Staff had sufficient opportunities to review and develop their working practices. Records indicated staff were expected to regularly attend individual supervision meetings with their line manager and group meetings with their co-workers. Several members of staff told us they felt they got all the support they needed from the management team. Managers told us that in addition to the meetings described above senior staff regularly carried out direct observations of staff performing their work.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. We saw appropriate arrangements were in place to ensure people consented to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. This gave staff the information they needed to understand people's ability to consent to the care and support they received. We saw staff always offered people a choice and respected the decisions they made. For example, during lunch we observed staff ask people to choose what they wanted to eat from the daily menu. Staff we spoke with demonstrated a good understanding and awareness of people's capacity to consent and to

make decisions about their care and support. Managers had identified that some people required their liberty to be deprived in order to keep them safe and free from harm. The registered manager had applied to the local authority for authorisation to deprive people of their liberty and maintained records about the restrictions in place and when the authorisations were due to be reviewed.

People were supported to have enough to eat and drink. People typically described the quality and choice of the food and drink they were offered at the home as "good". One person told us, "The food is exceptional. I particularly like the porridge at breakfast time." Another person said, "The staff always give you a choice about what you eat and drink." We saw there were 'night time' menus conspicuously displayed throughout the home which enabled people to order food and drink during the night which included hot and cold meals such as beans on toast and sandwiches.

We saw care plans included information about people's food preferences and the risks associated with them eating and drinking, for example where people needed a soft or pureed diet. We observed staff offering people drinks throughout the day and jugs full of water or juice were available in peoples' bedrooms. People's nutrition and hydration was provided in a way that met their specific needs, which included providing thickened fluids and soft diets. Staff demonstrated good awareness of people's special dietary requirements and the support they needed. Several staff gave us good examples of how they offered people different foods to find out what they did like to eat if someone living with dementia was losing weight.

People were supported to maintain good health. People told us they had access to a range of community health care professionals including GPs and district nurses. One person said, "The staff make sure I see the GP that comes here whenever I need to." Another person told us, "'I see a physiotherapist twice a week and I'm definitely getting stronger as a result." Staff ensured people attended scheduled appointments and check-ups such as with their GP or consultant overseeing their specialist health needs. People's individual health action plans set out for staff how their specific healthcare needs should be met. Staff maintained records about people's healthcare appointments, the outcomes and any actions that were needed to support people with these effectively. Staff we spoke with were knowledgeable about recognising signs and symptoms that a person's health was deteriorating. They liaised with the nursing staff if they had concerns about a person's health so that additional medical support could be obtained.

People told us Fieldway was a comfortable place to live. One person's relative said, "The home always looks well maintained and clean." However, we saw signage used in the home to help people orientate and to identify important rooms or areas such as their bedroom or the lounge, varied considerably. For example, although we saw there were some signs up in the home to help people identify toilets and bathrooms, most bedroom doors lacked any visual clues to help people recognise their rooms. We also saw communal areas such as hallways and bedroom doors, which had recently been redecorated, had been painted identical colours. This lack of colour contrast meant a lot of the communal areas looked the same. We discussed this matter with the service's management who agreed to review the home's colour scheme and redecoration, especially in hallways, and consider putting up easier to understand signs and visual clues throughout the home, including having an individual's name, family photographs or familiar objects displayed on or near a person's bedroom door. This might help people living with dementia orientate themselves and find their way around the home more easily. We recommend that the service seek relevant guidance and research on the design of the environment for people living with dementia.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and staff received the highest praise from everyone we spoke with. People and their relatives typically described staff as "friendly", "helpful" and "respectful". One person said, "Staff are interested in me. I think it's more than a job to them. They're always laughing with us." Another person told us, "The staff are all great and I particularly like one of the nurses who always looks after me." People's relatives were equally complimentary about the home. One relative commented, "It's a good home and the staff are lovely. I would recommend the home to anyone, and I mean that most sincerely." We also saw the service had received a number of written compliments from people's relatives since our last inspection. One relative wrote, "I would say that I have nothing but the highest possible praise for the home. The standard of care my [family member] received was absolutely superb."

We observed positive relationships had been built up between staff and the people living in the home. Staff focused on people and they seemed to genuinely enjoy the company of the people living at Fieldways and their visiting relatives, which added to the friendly feel of the home. People looked at ease and comfortable in staff's presence, responding positively to their questions and requests for assistance. Staff also gave people their full attention during conversations and spoke to people in a kind and considerate way. During lunch we saw a member of staff support a person who had become anxious to stay calm. The care worker spoke softly and reassuringly to this individual and in doing so was able to gain their trust and help them eat some of their lunch. We also saw staff frequently checked if people were enjoying their meal or needed a drink and provided encouragement. Staff described the food before supporting people to eat it and assisted them in a dignified manner.

Care plans were personalised and centred on people's needs, strengths and choices. There was detailed information about what was important to the person. People's life histories and the names of family members and friends who were important to them were recorded in their care plan. Staff knew people well and were able to tell us about what certain individuals liked to do, their social interests, preferred routines and background. For example, staff were able to tell us about the country of birth, the professional careers and hobbies of several people we spoke with and whose care plan we looked at.

People's privacy and dignity were respected and maintained. People and their relatives told us staff knocked on bedroom doors and asked permission to enter before doing so, which we observed staff do throughout our inspection. An independent health and social care agency who reviewed the service in 2016 concluded in their subsequent 'Dignity in care' report that people living in the home were treated with the utmost dignity and respect by staff. The report cited several examples of good practice in this area including addressing people by their preferred name, bedrooms being personalised and people being appropriately dressed. We observed these good practices being performed by staff throughout our inspection.

The service also had a named nurse who was a 'Dignity Champion' whose primary role was to ensure staff remained aware of how to respect and treat people with dignity and respect. Staff gave us some good examples of how they respected people's dignity which included, ensuring bedroom and toilet/bathroom doors were kept closed when they were supporting people with their personal care and calling several

people by the nickname they preferred to be known by.
Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. Information about people's spiritual needs were included in their care plan. One person told us, "The cook sometimes makes us Caribbean style food after I told them that's where I'm from and that's what I enjoyed eating." It was clear from comments made by staff that they were fully aware of the dietary requirements of this person and knew how to meet them. We observed the chef prepare a meal for the person which reflected their specific religious dietary needs and wishes. Religious leaders from various faiths regularly visited the home to support people to meet their spiritual needs and wishes.

Although most people living in the home were dependent on the care and support they received from staff with day-to-day activities and tasks, staff still encouraged people to be as independent as they could be. For example, we saw people could move freely around the home. We also observed people who were unable to use traditional cups and plates had their needs assessed and where appropriate, had been given a plate guard or special crockery which enabled them to drink and eat with minimal assistance from staff.

When people were nearing the end of their life, they received compassionate and supportive care. Staff told us they asked people for their preferences in regards to their end of life care and documented their wishes in their care plan. This included conversations with people and their relatives, about their decision as to whether to be resuscitated and whether they wanted to be hospitalised for additional treatment and in what circumstances. Staff confirmed they had received end of life care training.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission and personalised care plans developed. This ensured staff knew how to deliver care and support that met people's needs and wishes. Care plans were kept up to date and contained personalised information about people's social interests, food preferences and how personal care and support was to be provided. For example, people's daily routine set out for staff when people liked to wake up, how they wished to be supported with getting washed and dressed and when and where they would like to eat their meals.

Care plans were reviewed monthly, or sooner if there had been changes to people's needs. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff. Staff knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes.

Staff were also knowledgeable about the people they were supporting, knew what was important to them and provided support in line with people's needs and expressed wishes. For example, staff were able to explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people were able to do independently. During our inspection we saw staff had left one person's bedroom door open and another person had their radio tuned to a specific station they liked, which was clearly stated in their care plan. Each person had a keyworker. This was a member of staff assigned to a person to make sure their care needs were met, and their choices about their care were known and respected. Several staff told us key working had helped them build positive caring relationships with people and to get to know them well.

People were given 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. One person said, "Staff never fails to come around and ask me what I would like to eat and drink at mealtimes." Another person told us, "It's up to you if you want to spend time in your room reading or watching telly or join in the group activities they sometimes have in the lounge." Throughout the day we heard staff ask people where they wanted to be and what they wanted to eat and drink. For example in one exchange we heard a member of staff ask, "Would you like to have your lunch in your room or the dining room today?"

People had opportunities to participate in meaningful social activities. In the services most recent stakeholder survey, which was conducted in 2016, over half the people who responded said they were not satisfied with the range and quality of the social activities offered at Fieldway. The feedback we received from people and their relatives during our inspection was also rather mixed on the subject, although most felt the two new activities coordinators had significantly improved the service activity programme in the last six months. Typical comments made by people included, "There's not enough activities here, which can make Fieldway a boring place to live", "There wasn't much going in on here last year (2016), but I think the new activities coordinators are doing a really good job to improve the activities programme" and "There seems to be a lot more going on these days. I particularly enjoy the trips out. The new activities staff are very good."

We spoke with the lead activities coordinator, who confirmed they had been in post for six months. We observed them initiate an arts and craft session in a communal lounge, which people who joined in seemed to enjoy. The activities coordinator gave us several good examples of new activities they had introduced, which included gentle exercise classes, dancing, bingo, sing-alongs, quizzes, gardening, hairdressing, reminiscence groups, film presentations, and trips out to museums, the theatre and the coast. It was also evident from care plans we looked at and comments we received from the activities coordinator they ensured people who liked to spend time on their own also had opportunities to engage socially with staff in their bedroom. They explained the rationale behind this was to mitigate the risk of these individuals becoming socially isolated.

The provider responded to complaints appropriately. People and their relatives told us they felt able to raise a complaint if they had any concerns about the service provided at the home. A persons relative told us, "In the past I have felt the need to formally complain to the manager about the care my [family member] received here, and to be fair to the manager they took on board what I had to say and lately I've seen great improvements in my [family members] care." The provider had a robust complaints procedure that was designed to ensure people's complaints were dealt with in a prompt and fair manner. The complaints procedure was openly displayed in the home and explained what people should do if they wished to make a complaint or were unhappy about the service they received. The provider had a positive approach to using complaints and concerns to improve the quality of the service. Complaints were dealt with by the provider's management team. The complaints records showed that complaints lodged at the service had been taken seriously, investigated and where required action taken and lessons learnt.

Good

Is the service well-led?

Our findings

The service has a registered manager in post who knew the people who lived at the home well. They demonstrated a good understanding of their role and responsibilities particularly with regard to legal obligations to meet CQC registration requirements and for submitting statutory notifications of incidents and events involving people using the service.

There was a clear leadership structure in place. The registered manager was supported by a regional director and a regional manager, as well as a deputy manager and a clinical lead nurse who were both permanently based at Fieldway. Senior nurses and other members of staff were designated champions in areas such as dementia awareness, medicines management and infection control.

The provider had established good governance systems to monitor and review the quality of care they delivered. This included regular daily, weekly and monthly audits completed by managers and senior staff who worked at the home, as well as quarterly quality monitoring visits undertaken by regional directors and managers. We saw audits had been conducted in areas including care plans and risk assessments, medicines management, food hygiene and nutrition, staff training and supervision, health and safety, and accidents and incidents. For example, we saw the provider used an electronic system to monitor staff training which automatically flagged up when staff training needed to be refreshed. The home's maintenance records also showed that equipment was routinely serviced and maintained to reduce possible risks to people.

Through the aforementioned governance systems the registered manager had identified several issues which they had begun to address. For example, the registered manager explained how they had helped the housekeeping manager develop new guidance and training sessions for staff about ensuring people's meals always looked presentable and appetising after they had observed some poor practice in this area during a quality monitoring spot check.

The provider promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people living in the home and their relatives. A relative told us, "I think the manager is approachable and will always take time out to hear what you have to say." The provider used a range of methods to gather stakeholder views which included regular meetings for people living in the home and their relatives, and annual satisfaction surveys. All the satisfaction surveys that had been completed and returned to the provider by people in the past 12 months were generally happy with the standard of care they or their member had received at the home. The registered manager gave us a good example of action they had taken to employ two new activities coordinators in response to negative feedback received from over half the people who participate in last year's stakeholder satisfaction questionnaire.

The provider valued and listened to the views of staff working in the home. Staff spoke favourably about the registered manager's leadership qualities and said they were always approachable and supportive. One member of staff told us, "I have a lot of time for the manager. They're easy to get along with and she does listen to us." Staff meetings were held monthly and staff said they were able to contribute their ideas.

Records of these meetings showed discussions regularly took place which kept staff up to date about people's care and support and developments in the home.

The registered manager and staff worked closely with the local authority, the clinical commissioning group (CCG), acute and community healthcare services to review joint working arrangements and to share best practice. For example, staff regularly attended training provided by an NHS palliative care nurse to learn more about how best to support and care for people living in a nursing home who needed end of life care.