Fieldway Residential Home limited

Fieldway Residential Home

Inspection report

5 Fieldway
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Stoke On Trent
Staffordshire
ST11 9HS

Tel: 01782388332

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 October 2017 and was unannounced. At our previous inspection in November 2016 we found that the service was not always responsive or well led. We found a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as complaints were not managed appropriately. At this inspection we found that improvements had been made in this area and they were no longer in breach of this regulation. However we found further concerns and a further three breaches of Regulations as the service was not consistently safe and well led. You can see what action we have taken at the end of the report.

Fieldway Residential Home provides accommodation and personal care to up to 18 people. There were 17 people using the service at the time of this inspection, several who were living with dementia.

There was a registered manager in post who supported us throughout the inspection. 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.

The maintenance and management of the building and environment was not sufficient to maintain people's safety.

There were sufficient staff to meet the needs of people who used the service as the registered manager took action to increase the staff. However checks to ensure people who volunteered or regularly visited the service were not carried out to ensure their suitability.

People who manage their own medicines were not supported to do so safely.

People were not always considered and at the centre of the service as action was not always taken to keep people safe.

The systems the provider and registered manager had in place to monitor and improve the quality of the service were not always effective.

Risks of harm to people were reduced following incidents and accidents.

People were safeguarded from the risk of abuse as the registered manager followed the local safeguarding procedures.

The principles of The Mental Capacity Act 2005 were followed to ensure that people who lacked the mental capacity to agree to their care were supported to do so in their best interests.

Staff received training and support to be able to fulfil their roles effectively.

People were encouraged to eat and drink sufficient amounts of food and drink to remain healthy. When people became unwell or their health care needs changed the appropriate health care support was gained in a timely manner.

People's care was regularly reviewed and the staff and registered manager responded to any changes to ensure people's needs were met.

People were supported to be involved in hobbies and activities that met their individual preferences. People knew how to complain and complaints were responded to appropriately.

People told us they were treated with dignity and respect and their right to privacy upheld. People were offered choices about their care and these choices were respected.

There were plans in place to improve the service which were yet to be implemented. People, relatives and staff liked and respected the registered manager.

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 consistently safe.

The environment was not always maintained and equipment was not always stored safely to ensure that people were safe.

Checks to ensure people were safe and appropriate to volunteer and visit the service had not been carried out.

Not all medication was stored and managed safely.

There were sufficient numbers of suitably trained staff to keep people safe.

People were protected from the risk of abuse and action was taken to minimise the risk of further incidents which could result in harm.

Is the service effective?

Good

The service was effective.

Staff received support and training to be effective in their roles.

The principles of the MCA were being followed to ensure that people who lacked mental capacity were supported to consent to their care at the service.

People were supported to eat and drink sufficient amounts to remain healthy.

When people became unwell or their health needs changed, health care advice and support was gained in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to safety was not always considered.

People told us they were treated with dignity and respect.

People were offered choices and their choices were respected.

People's right to privacy was up held.

Is the service responsive?

Good

The service was responsive.

People's care needs were regulary assessed and responded to according to their individual preferences.

People were offered opportunities to engage in hobbies and activities of their liking.

There was a complaints procedure and people felt confident that their complaints would be dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems the provider had in place to monitor the quality of the service were not always effective.

The provider was in the process of making plans to improve the service through staff recruitment and changes to the senior team.

People, relatives and staff liked and respected the registered manager.

Fieldway Residential 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 inspection took place on 5 October 2017 and was unannounced. It was undertaken by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at notifications sent to us by the registered manager and used the action plan they had sent us following our previous inspection to inform the inspection. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We had received information of concern which we discussed with the registered manager at the inspection.

We spoke with five people who used the service and two visiting relatives. We spoke with the registered manager, the administrator and two care staff members.

We looked at the care records for three people who used the service, two staff recruitment files, staff rosters and the systems the manager had in place to monitor the quality of service. We did this to check the management systems were effective in ensuring a continuous improvement of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had no concerns in the safe care and treatment of people who used the service. At this inspection we found that there were some areas that required improvement and the provider was in breach of Regulation 12 and 19 of The Social Care and Health Act 2008 (Regulated Activities) Regulations 2014.

One person who used the service took their own medication which they kept in their room. Whilst talking to the person we saw that their medication was easily accessible to other people who used the service should they enter the room and take it. The person told us that one person who was living with dementia had been in their room uninvited on several occasions. This meant that this person and other people who used the service living with dementia were at risk due to the unsafe storage of this medication.

We looked around the building and we saw several bedroom doors were propped open with items to prevent the doors closing. This meant that if there was a fire and the fire alarms sounded these doors would not shut as is required in the event of a fire. We saw one person's bedroom door caught on their newly fitted carpet and did not close properly. This meant that in the event of a fire these people were at risk as the bedroom doors were fire doors which would prevent the spread of the fire. We reported this to the fire service following our inspection who then visited the service and found that action had been taken to rectify these issues.

We saw that the kitchen door was left open and unsupervised at times throughout the day. We saw one person who was living with dementia wander in and out of the kitchen freely. This put this person at risk of harm as there was electrical and gas equipment and materials in the kitchen that could put the person at risk if they handled it or ingested anything. We discussed this with the registered manager who recognised that people who used the service may be at risk if they entered the kitchen unsupervised.

We saw that the laundry door was left unlocked and there was equipment and materials such as cleaning materials which people who used the service had easy access to. We saw there were substances within the unlocked bathroom and fish food and cleaning solution readily accessible in the conservatory. Several people who used the service were living with dementia and may not understand the dangers of the materials if misused or ingested. The provider is required to follow the COSHH guidelines. COSHH is the law that requires employers to control substances that are hazardous to health. This meant that people were at risk of harm due to the control measures not being carried out to ensure people did not have access to unsafe materials.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see is safe recruitment procedures were being followed. We found that not all people entering the building on a regular basis or volunteering for the service had been checked for their suitability and safety. This included having a disclosure and barring service check (DBS). DBS checks are made against

the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that the provider could not be sure that people entering the building were fit and of good character.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered manager informed us that one person's anxieties and behaviour had deteriorated due to their dementia and they were requiring more staff support. They told us that at periods of heightened anxieties they had implemented one to one staff support. However, they had not increased the staffing levels to do this but used the existing hours they had. We saw that there were three staff on duty and one of these staff members was responsible for administering the medication. There were two people who were being cared for in bed and required two staff to support them to reposition on a regular basis. This meant there were times when there would be no staff available to other people who used the service. Staff we spoke with told us that it was becoming increasingly difficult to meet everyone's needs whilst the one person required one to one support. During the inspection the registered manager contacted the local authority for support. They informed the registered manager that they would not fund the extra hours until a full assessment of the person's needs was completed the following week. This meant that although the registered manager had reduced the risk for one person who used the service they now had insufficient staff to meet the needs of other people who used the service. During the inspection the registered manager arranged for adequate staff cover to support the one to one care for this person.

People were safeguarded from abuse and the risk of abuse. One person who used the service told us that another person who used the service had entered their room uninvited and threatened them. They told us: "You shouldn't have to live on tenterhooks should you?" We spoke with the registered manager who showed us that a safeguarding referral had been made to the local authority and they had implemented one to one staffing at the times the person was anxious and likely to wander into people's rooms. This meant that action was being taken to prevent possible abuse and protect people who used the service.

A relative told us that they felt their relative was safe at the service. They said: "It's a weight off our minds them being here". We saw when there had been an accident or incident which had resulted in harm or potential harm that action was taken to minimise the risk of it occurring again. For example, one person had recently fell out of bed and they told us: "I've got bed rails on my bed now to prevent me from falling again it makes me feel safe".

We looked at the communal management of medicines and saw they were stored and managed safely. Medicines were administered by staff who were trained to do so and there were regular audits of medication to ensure that people had their medicines as they were prescribed. The registered manager did take action to rectify the situation with the one person and the unsafe storage of their medicines before the end of the inspection by putting the medication in a secure tin.

Good

Is the service effective?

Our findings

At our previous inspection we had no concerns about the effectiveness of the service. At this inspection there were still no concerns and the service remained good in this area.

Staff we spoke with told us that they received support and training to be effective in their roles. One staff member told us: "I have just completed my NVQ level 3, I like it here and feel supported to do my job". Another staff member told us: "Both the registered manager and deputy manager are supportive; we have one to one time with them to discuss how we are getting on". There was an on-going training programme which was monitored and kept up to date.

People who were able to consented to their care and support at the service. One person told us: "I chose to live here because I had family that lived here previously, I looked at other places but liked it here best".

The 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was still working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people who lacked the mental capacity to agree to being at the service had been referred for a deprivation of liberty safeguards authorisation. The registered manager told us that they had recently referred one person for an 'urgent' DoLS as they had been found out of the service and this could have caused them harm due to fact that they lacked the mental capacity to keep themselves safe. This meant that the registered manager was ensuring that people when they lacked the mental capacity were being supported to consent to their care and support at the service.

One person told us: "The staff give me the things I like, like corned beef hash and I really enjoy the puddings and I always have plenty to drink like tea and juice". Another person told us: "The food is excellent, they will make you something else in a flash if you don't like what's on offer". If people required extra support with eating and drinking they received it. A relative told us: "The staff have just started using a plate guard with my relative as it helps them keep the food on the plate". We saw when people lost weight that they were supported to see their GP and some people were prescribed food supplements. This meant that people were being supported to eat and drinks sufficient amounts to remain healthy.

When people's health needs changed or they became unwell we saw that the registered manager and staff took prompt action to gain the healthcare support they required. For example, we saw one person had become unresponsive and the staff member recognised that the person was a diabetic and may be

experiencing low blood sugars. They called the paramedics who took the person's blood sugars and they were low as suspected. The person was treated for the low readings and they responded and recovered quickly. We saw another person's mental health had deteriorated and the registered manager had taken action to refer them to a community psychiatric nurse (CPN) for support. We saw that the staff were following the advice of the CPN and were recording all incidents of the person becoming anxious so the CPN could help formulate a plan to support the person.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found no concerns in how people were treated. At this inspection we found that although people told us they were treated with dignity and respect that not all of the actions being taken demonstrated that people who used the service were being considered and respected.

People's safety was not always being considered due to the issues relating to fire safety, access to COSH and people entering their home whom had not had the appropriate clearances. This did not show respect for people who used the service and demonstrate that people were at the centre of their service.

One person who used the service told us: "The staff are fantastic, I can't fault them". A relative told us: "I can't fault it here; they treat my relative with respect and me too. The thing is the staff listen and work around things to make things work". We observed the interactions between staff and people who used the service and saw that they were respectful and kind.

Two people told us how staff supported them with their personal care in way that maintained their dignity. One person told us: "It took a while getting used to staff bathing you but the staff help it in such a way they don't embarrass you". Another person told us: "The girls are very good; they don't make me feel embarrassed when helping me with my continence needs even the young ones". This showed that people were being treated with dignity and respect.

People told us and we saw that they were offered choices and their right to privacy was upheld. Some people chose to stay in their rooms during the day and this was respected. Two people remained in bed all day due to their health needs. A member of staff told us: "We ask people every day if they would like to get up, last week one person got up to watch the entertainment, and then when it ended asked to go back to bed.

Good

Is the service responsive?

Our findings

At our previous inspection we had concerns that complaints were not always managed appropriately and the provider was in breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and there was no longer a breach of this regulation.

One person told us: "If I had any concerns I would speak to [manager's name] and she would sort it". We looked at the complaints record and saw that since the last inspection there had been one complaint made. We saw that the complaint had been investigated by the registered manager and an apology had been issued to the complainant. The complainant was noted to be happy with the outcome of the investigation. We saw the complaints procedure was visible in the reception area and the registered manager told us that following the last inspection they had ensured that everyone had received a copy of the complaints procedure as a reminder of the process. This meant that people's complaints were being listened to and acted upon.

At our previous inspection we were concerned that not everyone was being supported to engage in activities that met their individual preferences. At this inspection people told us that they were offered opportunities to become involved in hobbies and activities of their liking. One person told us: "I like it when the singers come, they are very good". Staff told us that they supported some people into the community. One staff member told us: "I take [person's name] out to the local shop and they really enjoy that". The person confirmed that they had been out with staff however they couldn't remember when it was. We saw one person enjoyed dancing and staff engaged in this periodically throughout the day and the person was happy and relaxed when participating in this activity.

People's needs were regularly assessed and the registered manager responded when their needs changed. For example, one person required more staff support when anxious and the registered manager had responded and put this in place. Staff told us and we saw that there was a regular handover of information at the change of shift to ensure that staff were aware of people's current care needs. We observed that staff knew people well and knew how to respond to their individual needs and preferences.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we had concerns that improvement to the care people received was not always being monitored effectively to ensure a continuous plan of improvement. At this inspection we found further improvements were required in this area and the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we had noted that the activities people were involved in were not routinely recorded to ensure that everyone was offered the opportunity to engage in hobbies and activities of their liking. At this inspection there were still no records of what people were offered to do or had enjoyed doing. One person had told us that they had been out however they were living with dementia and were unable to tell us when. This meant that the provider could not be sure that this person's and other people's needs were being routinely met in relation to activities as they would not know when the person had last been involved in an activity.

We saw that there were some areas of the service that required maintenance. There were no maintenance records or plan to prioritise the jobs that needed doing so some areas of were being forgotten. We saw one person's bathroom pipes required lagging as they were at times hot to the touch and the person was living with dementia. The registered manager knew they needed making safe, however a maintenance log would have ensured that this job was prioritised and not overlooked.

The weekly fire checks that the registered manager carried out had not identified that some people's bedroom doors would not close in the event of a fire. This meant that this check was ineffective in ensuring the desired improvements were made and left people at risk.

Some people's care plans and risk assessments had not been updated following recent reviews of people's care. This meant that staff did not always have the most up to date information to be able to care for people safely.

There were no staff meetings to discuss and agree ideas to improve the quality of the service. The registered manager told us that this was because staff would not attend when asked. A relative told us that there were no relatives or resident meetings. These would have benefitted the registered manager in gaining people's feedback on the quality of service they were receiving.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we asked one member of staff to talk to us about their experience at working at the service and they refused. This did not demonstrate a professional approach to the inspection process.

We saw that the registered manager had a quality assurance plan which in some areas had been successful in bringing about improvements to the service. For example, we saw that the registered manager had asked

for decking in the garden which would aid people to be able to sit out in the garden in the summer. We saw that this was being completed on the day of the inspection and looked a pleasant area for people to enjoy next spring and summer.

The registered manager analysed falls and we saw that they took action to reduce the risk of falls when it was identified that improvements were required. For example, one person had a sensor mat put in place to alert staff to them walking and another person had bed rails put in place to prevent them falling from bed again.

Since the last inspection the provider had employed an administrator to support the registered manager in the financial aspects of running the service. The registered manager and administrator told us that they were trying to recruit new staff however they were having difficulty in finding potential staff to apply. They told us of plans to improve the quality of the service and were responsive to our feedback.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care that was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not being protected as staff working or volunteering at the service had not all been cleared to work with vulnerable people.