Fieldway Residential Home limited

Fieldway Residential Home

Inspection report

5 Fieldway
Adamthwaite Drive, Blythe Bridge
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?	**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 took place on the 24 February 2016 and was unannounced. At our previous inspection in 2013 there were no concerns identified in the areas we inspected.

Fieldway Residential Home provided accommodation and personal care to up to 18 people. There were 13 people using the service at the time of the inspection some of whom were living with dementia.

There was 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 did not always have their medication when they needed it as instructions from the prescriber were not always followed.

The principles of the Mental Capacity Act 2005 were not followed. Some people were being restricted of their liberty and people were not being supported to consent to their care and support.

People were not supported to engage in hobbies and activities of their choice. The environment did not support people living with dementia to orientate to time and place.

There were sufficient staff to meet the needs of people who used the service. Safe recruitment procedures had been followed to ensure they were fit to work with people.

Risks of harm to people were assessed and action was taken to minimise the risk through the use of risk assessment and equipment.

Staff were supported and received training to be able to fulfil their role effectively.

People's nutritional needs were met and if they became unwell health professional support was gained. People were supported to access a range of health care professionals.

People were treated with dignity and respect and their privacy was respected.

People's care was regularly reviewed however people themselves were not involved in the reviewing of their care.

The provider had a complaints procedure and people knew how and who to complain to.

There were systems in place to monitor the quality of the service and action was taken to improve.

There was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end 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 consistently safe. People did not always have their prescribed medicines at the time they needed them. People were safeguarded from abuse as staff knew what to do if they suspected someone had been abused. Risk of harm were assessed and action taken to minimise the identified risk. There were sufficient staff, employed using safe recruitment procedures to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective. The provider was not following the principles of the MCA by ensuring that people were consenting to their care.
Staff received support and training to be able to fulfil their role effectively. People had sufficient to eat and drink and their nutritional needs were met. People had access to a range of health care professionals and if they became unwell appropriate advice was sought.

Is the service caring?

Good

The service was caring. People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People were not being supported to participate in hobbies and activities of their choice. People or their representatives were not involved in the reviewing of their care.
The provider had a complaints procedure and people knew how to use it.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The registered manager was not following the principles of the MCA and ensuring that people were not being restricted of their liberty and consented to their care.
Staff felt supported by the management. Systems were in place to monitor the quality of the service. Action was taken when areas of improvement were identified.

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

This inspection took place on 24 February 2016 and was unannounced.

The inspection was undertaken 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.

We reviewed the information we held about the service. This included safeguarding concerns, previous inspection reports and notifications of significant events that the registered manager had sent us. These are notifications about serious incidents that the provider is required to send to us by law.

We spoke with five people who used the service and observed other people's care. We spoke with two relatives, two care staff, the deputy manager, the registered manager and a visiting health professional.

We looked at the care records for four people who used the service, and the systems the provider had in place to monitor the service. We looked at two staff recruitment files and the staff rosters. We checked people's medicines and medication administration records. We did this to check the effectiveness of the systems the provider had in place to maintain and improve the quality of service being delivered.

Requires Improvement

Is the service safe?

Our findings

We looked to see how people's medicines were managed and saw that they were stored safely and administered by trained staff. However we saw that one person was not having their medication as instructed on the prescription. The registered manager told us that the person's community nurse had suggested that the person had the medicines at different times throughout the day than what their GP had prescribed. The staff had begun to administer the medicines at the suggested times but this had not been agreed by the GP who had prescribed the medicines. This meant that the staff were not following the instructions on the prescription and could not be sure that they were safe to have at the times suggested. We saw that the same person had not been given another medicine as prescribed for a period of three weeks. The registered manager told us that they were waiting for confirmation from the person's GP as to whether they should still be taking this medicine following a change in the person's health. The registered manager told us that they had been contacting the GP for confirmation by telephone; however they had not been successful in them responding. This meant that this person was not having their medicines as prescribed and they were at risk of becoming unwell.

People who used the service felt safe. One person told us: "From day one I have been very comfortable here. I feel safe." Staff we spoke with all knew what to do if they suspected abuse. A member of staff told us: "If I had any concerns I would go to the manager or report it to CQC or the social services". The registered manager had made safeguarding referrals to the local authority for further investigation in the past when an incident had occurred.

People were supported to stay safe and take risks to promote their independence through the effective use of risk assessments. Risk assessments were in place for each person dependent on their needs and they were kept under constant review. We saw when an incident occurred action was taken to minimise the risk of it happening again, for example one person had a sensor on their bed which alerted staff when they were mobilising as they had fallen when trying to get out of bed. Other people had been assessed as requiring support with mobilising around their home. Some people required walking frames and another person required two members of staff and the use of a hoist to be able to move. We saw that the equipment and the staff were available to them when they needed them.

Staff we spoke with all told us that they felt there was sufficient staff to be able to meet people's needs. We saw that no one had to wait to have their care needs met and call bells were answered in a timely manner. We looked at the way in which staff had been recruited to check that robust systems were in place for the recruitment, induction and training of staff. Staff confirmed that checks had taken place and they had received a meaningful induction prior to starting work at the service.

Requires Improvement

Is the service effective?

Our findings

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. Some people who used the service required support to make decisions and to consent to their care, treatment and support because of their dementia. We saw that everyone had a 'consent to care' form which had been signed by people's relatives as their representatives. However the registered manager could not tell us if these relatives had lasting power of attorney and had the power to make the decisions on people's behalf. One person who lacked capacity to consent was being cared for in bed and the registered manager told us this was due to a change in their health needs. They told us that it had been discussed and agreed with just the person's relative. The MCA had not been followed to ensure that this decision was in the person's best interests.

The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. No one at the service had a DoLS authorisation in place and the registered manager told us that no one was being restricted of their liberty so no referrals had been made to the local authority. However we saw that some people were subject to constant supervision through the use of alarmed doors and were being restricted from certain areas of the service and through the use of bed rails. The registered manage had not recognised this as being a possible deprivation of people's liberty. A member of staff told us that people often attempted to leave the service and had to be persuaded to come back in as they were deemed not to be safe to go out alone. This meant that people were being restricted of their liberty without lawful permission.

These issues constitute a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that were supported and trained to fulfil their roles. Staff all told us that they had received regular training and this was on going with regular updates. Staff had regular one to one meetings with the registered manager to discuss their performance and identify any further training they may require. When areas of weaknesses were identified the registered manager took the appropriate action to ensure that staff were supported to improve.

People told us they liked the food. We saw that there were choices of main meals and the registered manager told us if someone didn't like the choices they could have what they liked. No one was on a special diet, although some people required support to eat and drink. We saw that staff sat with people and supported them at mealtimes. The registered manager told us that they monitored people's eating and drinking and if there were concerns they sought advice from the GP. A member of staff told us: "[Person's name] likes 'tomato ketchup' with everything; it encourages them to eat if we put it on their meals". We saw they had ketchup with their meal and they ate it.

People were supported to attend health care appointments with professionals such as their GP, opticians, dentists and community nurses. The registered manager and staff worked closely with other health agencies to ensure people's health care needs were met. We saw one person had fallen and although at the time they were told by the hospital staff they had not fractured a bone they continued to complain of pain. We saw staff at the service continued to raise their concerns with the person's GP and the person was later found to have a fracture. This showed that the staff were supporting people to have their health care needs met. A visiting health professional told us that the staff always sought advice appropriately and followed the instructions they left to care for the person. We saw that people had access to a wide range of health care facilities. When people became unwell we saw that action was taken to seek the appropriate medical advice.

Good

Is the service caring?

Our findings

People told us that they were treated with dignity and respect. A relative told us: "My relative is happy, they would tell me if they weren't. They enjoy having a joke with the staff". Another relative told us: "The staff give my relative lots of fuss and excellent care".

We observed that staff spoke with people in a kind and caring manner. One person was new to the service and became upset as they could not understand why they were there. We saw the registered manager explained in kind way why they were there and then redirected them to an activity they enjoyed doing. Being involved in the activity took the person's mind off their concerns.

People were encouraged to be as independent as they were able to be and were offered choices. A relative told us: "The staff have tried hard to keep my relative out of a wheelchair, by trying to keep them mobile". One person chose to get up at lunchtime every day and this was respected. Some people chose to eat their meals in the dining room whilst other people ate in the lounge areas.

People's privacy was respected. One person had a visit from a health professional as they required some treatment. We saw staff supported the person to their bedroom where they were able to be treated privately. The health professional told us: "If I come at meal times I am asked to wait until the person has finished, so they don't have to be disturbed whilst they're eating, I understand that so don't come at mealtimes now". This showed that staff were considering people's needs in relation to being disturbed at mealtimes.

Relatives were free to visit at any time and we saw frequent visitors throughout the day.

Requires Improvement

Is the service responsive?

Our findings

There were limited opportunities for people to engage in hobbies and activities of their choice. People we spoke with told us that there used to be activities but they had stopped. One person told us: ""I'm not bodily ill and I feel I could help them with bits of things. There's nothing worse than sitting. It's boring". People sat all morning in the lounge with the TV on but most people fell asleep until woken for a drink. One person told us: "The TV is on but we ignore it, you get used to it". We were told that staff struggled to engage people in any activity as people often refused. There were no sensory items available for people living with dementia to help stimulate and orientate them to time and place. People did not access the community unless they were supported by their family members, this would mean that some people would not be able to go out. In the afternoon, staff played some music and one person had a dance, other people looked on or slept. The registered manager told us that they did not have any external entertainment come into the service such as singers.

The registered manager reviewed people's care plans and risk assessments in detail on a monthly basis. However we could not see how the person themselves had been involved in reviewing their care. A relative told us: "We've not had a review in three years, but staff do keep me informed of my relatives welfare when I visit or if they are unwell".

Prior to admission into the service, an assessment of people's needs was undertaken by the registered manager to ensure they were able to meet people's needs. When people became unwell and were admitted into hospital we saw that the registered manager reassessed the person's needs to ensure that they could still be met at the service.

Relatives we spoke with told us that they would raise any concerns they had with the registered manager. One relative told us: "I trust the manager would respond if I had any concerns". The provider had a complaints procedure which was visible on the wall in the reception. We were told there had been no recent complaints.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, who kept themselves up to date with relevant training and legislation that affected the way in which the service should be run. However they had not recognised that some people may be being deprived of their liberty through constant supervision and aids that restricted people's movements. This meant that the principles of the MCA were not being followed and people were at risk of being unlawfully restricted.

Systems to manage people's medicines were not effective as one person was not receiving the medicine they were prescribed. Communication between the management team and the person's GP had not been effective and the person was at risk due to not having their medicines as prescribed.

Staff we spoke with told us that they felt supported by the registered manager. We saw that they offered staff support by working alongside them, completing care tasks. A member of staff told us: "The manager will always come and help us if we need it". There was a designated on call system to offer support in the event of an unplanned emergency.

The registered manager looked for ways to improve the service. They had recently applied for and received a local authority grant to replace a proportion of the lounge chairs. There were audits and systems in place to monitor the quality of the service, we saw these were undertaken regularly and any action to improve was taken promptly. For example the flooring in one of the bathrooms had been identified as needing replacing at one environment inspection. We saw that this was actioned and a new floor put in place.

Annual questionnaires were sent out to people who used the service and their relatives. We saw that the results of these were analysed. Last year's audit identified no areas as requiring improvement as people had put they were happy with the standard of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the MCA 2005 were not being followed and people were not being supported to consent to their care.