Roche Healthcare Limited

Fieldhead Court

Inspection report

Rectory Park
Church Lane
Dewsbury
West Yorkshire
WF12 0JZ

Tel: 01924459000
Website: www.rochehealthcare.com

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Fieldhead Court took place on 9 December 2015 and was unannounced. We previously inspected the service on 30 October 2013. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Fieldhead Court is a nursing home currently providing care for up to a maximum of 45 older people. The home is a converted property with a purpose built extension. The home stands in its own grounds with mature gardens. On the days of our inspection 42 people were living at the home.

The service had a registered manager in place. 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. Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

People told us they felt safe and staff understood their responsibilities in keeping people safe from the risk of abuse.

Risks to people's welfare had not been robustly assessed and relevant risk assessments had not always been implemented.

One of the staff recruitment files we looked at did not contain references to support their application to work at the home.

Staff received regular training and supervision, new staff were supported in their role.

Staff understood the principles of the Mental Capacity Act 2005, but, where people lacked capacity, there was a lack of documented evidence regarding the decision making process.

People told us staff were caring. We observed staff to be kind and attentive to people's needs. Staff respected people's right to privacy and dignity.

There was a varied programme of activities available for people and the activities organiser had plans to further develop the programme for people.

Care records contained a number of plans providing instructions for staff as to how people's needs were to be met. Documents within the files were easily located and were reviewed at regular intervals.

There was a system in place to record and respond to complaints.

The home had an experienced registered manager. Staff spoke highly of the registered manager and felt supported by them.

The registered manager and senior management team conducted regular checks to monitor the quality of the service people received.

Meetings were held with people who lived at the home and staff.

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.

People told us they felt safe.

Care plans contained a variety of risk assessments which reduced risks to people's safety and welfare.

People told us there were enough staff at the home to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Refresher training was not always up to date.

Where people lacked capacity, mental capacity assessments were not in their care plans.

People received support to eat and drink.

Is the service caring?

Good

The service was caring.

Staff were caring and kind.

Staff enabled people to make choices about their daily lives.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

There was an activity programme in place which people told us they enjoyed.

Care plans were reviewed and updated regularly.

There was an effective complaints system in place.

Is the service well-led?

Good

The service was well led.

There was an experienced registered manager employed at the home.

The registered manager was supportive to staff and encouraged them to develop their skills.

There was a system in place to monitor the quality of the service people received.

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.

This inspection took place on 9 December 2015 and was unannounced. The inspection team consisted of two adult social care inspectors. One inspector visited the service again on 10 December 2015, this visit was announced.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the local authority contracting team and continuing health care team. Before the inspection, we asked the provider to complete 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 used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with eight people who were living in the home and four visiting relatives. We also spoke with the registered manager, administrator, assistant deputy manager, two nurses, two team leaders, two care staff, a cook, a domestic and the activity organiser. We reviewed five staff recruitment files, five people's care records and a variety of documents which related to the management of the home.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe. Relatives of people who lived at the home said their family member was safe.

Staff told us they had received training in safeguarding vulnerable adults and were able to describe types of abuse and the action they would take in the event they were concerned someone was at risk of harm or abuse. One staff member said, "If there were any issues, I'd be the first to report it." The registered manager also told us they had completed role specific safeguarding training with the local authority and they were able to tell us how they made safeguarding alerts to the local authority. This showed the registered manager and staff were aware of their responsibilities in relation to safeguarding the people they cared for.

Each of the care plans we reviewed contained a number of risk assessments. For example, nutrition, skin integrity, mobility and falls. We asked a nurse if anyone at the home had a pressure sore, they said, "No, we pride ourselves on that. Any redness (of the skin) is reported to us and we go look, assess it. We use the Tissue Viability Nurse (TVN) if we need advice". Two of the team leaders we spoke with were clear about the action staff took to reduce people's risk of developing sores. We saw the registered manager had a system in place to ensure they were aware of people's monthly weight. We saw how they recorded this information and saw evidence of action being taken in the event a person had on-going or sudden weight loss.

We reviewed the care file of three people who had moving and handling needs and found information in the risk assessment to lack the detail required in a moving and handling risk assessment. For example there was lack of detail regarding the type of hoist and sling to be used. One person required the use of a wheelchair and equipment was also required when they were bathed or showered. The care plan did not contain risk assessments pertaining to the use of this equipment. This meant that risks to these people's welfare had not been robustly assessed and relevant risk assessments implemented. However, the registered manager assured us they would take action to ensure this detail was recorded in the moving and handling care plans. Accidents and incidents were recorded and analysed. The registered manager told us the system they used for this had been reviewed in July 2015 to include the location and times of falls. This showed the home analysed incidents that may result in harm to people living there in order to detect where changes to their care or support may be required.
Staff told us that in the event of the fire alarm being activated, staff met in the reception area where the fire panel was located. They said the senior person in charge of the home would then instruct staff as to the action they were to take. We saw a personal emergency evacuation plan (PEEP) was in place and retained in the reception area for ease of access in the event of an emergency. We saw regular checks were made on the fire detection system and there was evidence fire drills were completed at regular intervals. However, the training matrix recorded that seven of the 54 staff employed at the home had not attended a fire drill. Staffs participation in regular fire drills helps to ensure they are confident in their role and the actions required of them in the event of a fire.

We saw regular checks were made to ensure the premises and equipment were safe. For example, frequent checks were made on the nurse call system and we saw where a fault was identified, action was taken to

address the matter. Water temperatures were monitored to reduce the risk of scalding, however, we noted that checks on the bathroom water temperatures had not been recorded since August 2015. The home had a number of wheelchairs, the registered manager told us if a wheelchair was owned by an individual person, an external company checked it for safety at regular intervals but wheelchairs for communal use were checked by a staff member at the home. We saw five wheelchairs were logged as been checked by the care home staff but we had seen a greater number of chairs in operation at the home. The person who had responsibility for checking the wheelchairs said they could not always access the chairs as they were in use. When we returned to the home the next day the registered manager told us plans were in place to rectify this matter.

We looked at five staff recruitment files and saw a series of pre-employment checks were made to make sure potential candidates were suitable and safe, before they started working with people. Candidates had completed an application form and notes were kept of the interview. One of the staff files we reviewed was for a member of nursing staff and we saw evidence the registered provider had confirmed their professional registration was current. This showed the provider had ensured staff members were continuing to meet the professional standards that are a condition of their ability to practise. Each files contained two references which the registered manager said were obtained prior to staff commencing employment, and a Disclosure and Barring Service (DBS) check had also been completed. In one of the files we noted the DBS for one of the staff was dated December 2008. Although it is not mandatory these checks are renewed, we could not see any evidence that on-going suitability of staff was monitored and verified to ensure they remained suitable to work with vulnerable people.

People we spoke with did not raise any concerns regarding the number of staff available to support them. A relative said, "There are enough staff. We understand that the staff can't do everything immediately but they do things as soon as they can." Two people we spoke with told us that if they pressed their buzzer to call for staff they responded promptly.

When we spoke with staff they told us they enjoyed working in the home and there were sufficient staff to provide care for the people who lived there. Where staff absence was caused by sickness or some other reason they said senior staff always tried to get cover and the use of agency staff was minimal. This meant people were supported and cared for by staff who knew them well.

As part of our inspection we reviewed how people's medicines were managed. The medicines room was clean and a record was kept to ensure the temperature of the room and the medicines fridge were within safe limits. A monitored dosage system (MDS) was used for the majority of medicines with others were supplied in boxes or bottles. We checked a random selection of three people's boxed medicines and found the stock tallied with the number of recorded administrations. One person was prescribed a PRN medicine, this is a medicine which is prescribed to be taken 'as needed'. We saw there were instructions for staff to tell them when and why this medicine was to be administered.

One person's MAR recorded they were prescribed four topical medicines (creams). The nurse told us these were signed on the MAR by the nurse and the care staff also signed a further administration sheet which was kept in the person's room. When we checked the person room they only had a signing sheet for three of the prescribed medicines. This meant there was a lack of evidence to show staff were applying the cream in line with the instructions of the prescribing clinician.

A medicines audit was completed on a monthly basis and we saw no concerns had been identified. There had also been a recent audit completed by the supplying pharmacist and the local authority. No concerns were raised through either of these inspections.

The home was clean and tidy throughout, no unpleasant odours were detected. Personal protective equipment (PPE), for example, aprons and gloves were available in communal areas and we saw instructions throughout the home reminding staff of appropriate hand washing techniques. This showed the home provided a clean environment for the people living there.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us there was a handover between staff at each shift changeover. They said they attended the 7am handover whenever they were on duty. This was confirmed when we spoke with one of the nurses. This enabled them to have an in-depth knowledge of peoples care and support needs.

Staff told us they received regular training in a variety of topics, for example, moving and handling, safeguarding and food hygiene. The registered manager told us staff training dates were pre-set by head office for the year ahead to enable home managers to plan for staff to attend as required. They explained new staff completed three days initial office based training and then refreshers were done over two days. We saw from the training matrix that staff attended training and refresher training was on-going. Although of the 54 staff listed on the training matrix 17 staff had not completed first aid training and a further 27 staff had not refreshed this training for over 4 years. Ensuring staff receive up to date first aid training ensures they have the skills and knowledge to enable them to act effectively in the event of someone requiring emergency assistance.
The registered manager told us all staff who were responsible for administering peoples medicines received formal training and an assessment of their competency. They said they had just begun to review staff competency assessments on an annual basis, however, they said if any concerns were raised regarding a staff members ability, this would prompt a review of their skills. The training matrix did not record the date nursing staff completed this training and the information for the seven team leaders detailed three of them had not received training since 2011. When we spoke with staff who had a responsibility for administering medicines they told us they had received training, their competency had been assessed and they felt confident performing this role. We reviewed the training file for a nurse who had been employed at the home during 2015 and we saw evidence they had completed training and a record was also kept of an assessment of their competency. This meant we could not be assured people received their medicines from people who had up to date knowledge and skills.

Staff told us all new employees shadowed a more experienced staff member for one to two weeks and then they were partnered with a team leader. When we spoke with a staff member who had commenced employment during 2015 they told us how they had been supported by staff during the initial period of their employment. This demonstrated that new employees were supported in their role.

All the staff we spoke with told us they received regular supervision with the registered manager and they all said they felt they could speak openly at this meeting. One staff said, "We can put anything forward to (name of registered manager)." The registered manager showed us a matrix which provided an overview of all the staff and when they had received supervision. We saw all ancillary staff received supervision at least every six months and nursing and care staff received supervision on alternate months. This showed staff received regular management supervision to monitor their performance and development needs.

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. The registered manager told us two people at the home had a DoLS authorisation and they had applied for a further one.

The registered manager and the staff we spoke with expressed an understanding of the MCA and how this impacted upon the people they supported. One staff said, "It's about helping people with decisions and if they can't, making decisions in their best interest." We saw from the training matrix that staff had recently completed or refreshed their knowledge in this subject.

In each of the care plans we reviewed we saw either the person or their relative had signed to consent to the care and support they or their relative received. We looked at the care plan for one of the people who had a DoLS authorisation in place. The documentation clearly evidenced the person lacked capacity to make many of the decisions required on a daily basis but there were no mental capacity assessments in place. In another care plan we saw evidence of a best interest decision related to the use of a specialist chair but was this was not preceded by a mental capacity assessment. The registered manager told us staff did not include these assessments as part of the care planning process. This meant that care plans did not evidence the home was acting in line with the requirements of the MCA 2005.

We asked people about the meals they received at the home. One person said, "The food is great. I like plain food and I can get what I want when I want it." A relative told us they were having their Christmas dinner at the home with their relative."

We saw people being served their meals in the dining room, lounges or in their own bedrooms. People told us that they could choose what they had for breakfast and we heard staff offering them a choice of where to sit and who to sit with. People had a choice of porridge, cereals, toast and preserves and egg on toast.

We saw that there were two sittings at lunchtime, staff told us this was to ensure people who needed more support with eating could be supported first. Dining tables were laid out in individual places with napkins, sauces and condiments. Jugs of orange or blackcurrant cordial were available on each table. The atmosphere for the lunchtime meal was calm and uninterrupted with sufficient staff to attend to each person's needs where required. The lunchtime portions were adequate and there was little waste. However, the meal was plated up by staff which meant people did not have the opportunity to decide on the quantity of potatoes, vegetables or gravy they had on their plate.

Staff, and people we spoke with told us menu choices were made by people on the previous day although they could change their mind on the day or even opt for something entirely different and the kitchen would try to accommodate them. There were no menus apart from a whiteboard which had been updated with the current choices for that day but we had difficulty reading this because the writing was faint. People we spoke with could not always remember their menu choice from the previous day and did not appear to notice the whiteboard. This meant the method for people to choose their menu choices may not meet each person's individual needs.

Nutrition record sheets were kept for each person with a record of what they had eaten and drunk and when

they had declined this. We were concerned however that in one or two instances there were no entries. Staff could not identify what had happened at these times. We saw people were offered snacks with their mid-morning and mid-afternoon drinks but the nutrition record did not contain a section for staff to record these. It is important that where records of nutrition and hydration are kept that these are comprehensive and accurate.

We saw evidence in each of the care plans we looked at that people received input from external health care professionals. For example, the GP, dietician and speech and language therapy. This showed people using the service received additional support when required for meeting their care and support needs.

Good

Is the service caring?

Our findings

People told us staff were caring and kind. One person said, "The staff are kind." Another person who lived at the home said, "The staff are very good, they look after us very well. They are very obliging." A relative said, "I We looked at a few places before choosing Fieldhead Court but this was the most friendly. You can ask around, most of the people here and their families will tell you they are satisfied."

The registered manager told us they had a good staff team. They said, "Good staff keep people happy." A staff member said, "I expect residents to be treated like your own parents." When we spoke with staff about individual people who lived at the home, staff were able to tell us about their care and support needs including knowledge of people's abilities and preferences.

We observed staff to be kind, caring and attentive. Staff knew the people who lived in the home well and therefore had an understanding of their preferences. They treated people with dignity and respect. Staff we spoke with told us how they maintained people's privacy, for example, closing doors and curtains, covering people's bodies with towels during personal care. We saw staff knock on peoples' bedroom doors before entering and engaged people by name as they encountered them in the home.

We saw two staff using a hoist to help one person who lived there into a chair. They did this while reassuring the person they were safe. Staff offered people drinks spontaneously rather than waiting for a person to ask. Staff took care to spend time with people who lived in the service.

During mealtimes staff had a good understanding of the assistance people needed but asked them before offering this by saying, for example, "Would you like me to help you with that?" and waiting for the person to reply. People we spoke with told us staff offered them choices. One person said, "They ask me if I want to go to bed, and they ask in a morning. You can say 'no', and they come back later." Another person told us, "They come and ask me if I want to get up." We asked one person if they were enabled to bathe regularly, they told us they had a bath every week, "If I want another one, I just ask."

However we noted that staff did not wear any form of identification and that there was no other means such as a photo gallery so that people who lived in the home or relatives would easily know their names. This meant people and visitors to the home were not always able to clearly identify staff or their role within the organisation.

Good

Is the service responsive?

Our findings

We asked relatives and visitors to the home what activities were available to engage people during the day. One person who lived at the home said, "I like joining in the activities, particularly the physical activities." Another person we spoke with told us, "One of the staff is very good at providing entertainment and quizzes."

We saw a programme of activities was on display in the entrance to the home. These included discussions and pamper sessions, as well as visits from the hairdresser, quizzes and board games. During our inspection we saw the activities' organiser leading armchair sports for the people who lived in the home. In the afternoon we saw an outside entertainer had been engaged to provide an activity designed to stimulate memory. We saw that these activities were well attended and in the afternoon the majority of people who lived in the home were in attendance. We were also told that trips out were organised for groups of people who lived in the home using a minibus shared with other care homes operated by the registered provider.

We talked with the activities' organiser who told us they worked full-time at the home. They said they were quite new in post but had previous experience of working with older people. They said they had also attended a meeting with other activity organisers from other care homes, organised by the local authority. They showed us some of the materials they had obtained from this meeting and the ideas they had about new activities.

There were some facilities which were intended to support people with memory difficulties. A large calendar in the dining room displayed the correct day and date. There was a reminiscence corner in the smaller quieter lounge where we were told a small group of around eight or nine people would meet with the activities organiser to share memories. One person who lived there had a copy of a daily national newspaper and we were able to use this to engage in conversation with them.

Each of the care plans we reviewed was neatly organised with documentation easy to locate. There were a variety of care plans including, mobility, eating and drinking, personal care and sleep. All the care plans were reviewed and updated at regular intervals. The care plans were generic with a section for staff to personalise the plan to individual needs and preferences. For example, one person's sleep care plan recorded, '(person) likes the light off, lamp on, and the radio on until they are asleep'. Another person's eating and drinking care plan noted, '(person) does not have sauces, gravy or any dairy products'. However, we saw some care plans lacked this level of detail. For example, one care plan recorded the person liked a shave every day but did not record if this was to be a wet or dry shave. Another person's care plan noted the person could be aggressive during personal care but the record did not detail the strategy staff should employ to diffuse this situation. However, during our inspection we observed a person becoming upset with a particular staff member while they were being supported. We saw the staff reassure the individual before discreetly asking another staff member to replace them, this instantly diffused the situation. This meant we were reassured that although records may not consistently record a high level of detail, people were receiving person centred care which met their needs.

We asked people what they would do if they were unhappy with the service they received. One relative said, "The home is very much on the ball. Any minor problems I have mentioned have been sorted." Another relative said, "I've never had to make a complaint. The care is good, the food is good, no complaints."

We saw the home had a complaints policy which had been revised within the last six months and a summary of the policy was displayed on the noticeboard in the main entrance to the home. Where complainants remained dissatisfied, information was provided about their right of access to the Local Government Ombudsman and the Care Quality Commission (CQC), although the CQC does not formally investigate complaints.

We looked at records of complaints and found there had been three complaints over the last year. One related to the care of a person who used the service whilst the other two were anonymous complaints which had been received through the CQC. We saw that in the first instance a full detailed response had been made to the relative of the service user. In relation to the other complaints a full investigation had been undertaken by the quality assurance section of the company which owned the home. In both these instances full information about the outcome of the investigation was included and a response made to the CQC. On each occasion the response was made within the required timescale outlined by the complaints policy. This demonstrated there was an effective complaints system available.

Good

Is the service well-led?

Our findings

The home had an experienced registered manager in post who had been employed at the home for ten years. Throughout the duration of the inspection they were open, professional and knowledgeable about the people who lived at the home and their staff. Staff we spoke all told us they felt supported by the manager and they could approach them with any issues or queries. Many of the staff we spoke with had worked at the home for a number of years. One member of staff said, "It's a lovely place to work." Another said, "I enjoy my job, and the people I work with." One relative said, "I know who the manager is, they are very approachable."

One of the staff we spoke with told us how their role had developed during their employment at the home and how the registered manager had encouraged them to take on a more senior role within the home. The registered manger told us they were currently working with the local authority to enable care staff to gain clinical skills which would provide further support to the nursing team. They said they continually wanted the home to improve and welcomed ideas which would improve the service.

The registered manager said they felt supported in their role and the both the registered provider and members of the senior management team were regular visitors to the home. We also saw evidence the service was monitored by senior managers. This included monitoring of maintenance issues, health and safety and care records and personnel matters.

The registered manager completed a daily walk about of the home which was documented. They said this was an opportunity to check a number of areas including staff practice, the environment and care records. We saw where issues were identified; we saw these were recorded, along with the action taken to remedy the matter.

The registered manager said they audited five peoples care records each month. We looked at the completed audits for September, October and November 2015. We saw the audit tool focused on ensuring the relevant documentation was in place, care plans and risk assessments were reviewed and relevant actions implemented. We saw where a shortfall was identified this was recorded although confirmation this had been actioned was not always recorded. We also discussed with the registered manager on the day of the inspection the need to ensure their audit also reviewed the content of people's care plans to ensure they provided a consistently high level of detail about people's care and support needs.

We asked one person if there were any resident meetings held at the home, they told us they had been invited to a resident meeting but they had chosen not to go. We saw minutes of meetings with relatives and people who used the home which covered a number of agenda items. For example, fundraising and enabling people to express any likes or dislikes they had about the home. Staff told us these meetings were held every six months.

Staff told us meetings were held regularly throughout the year. They said a general staff meeting was held every six months but meetings targeted at particular staff groups, for example, team leaders or heads of

department were held monthly or weekly as the need arose. We saw minutes of a general staff meeting, these covered a number of operational topics including new initiatives such as pursuing registration on the Gold Standard Framework for end of life care. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people living at the home.

We saw the registered manager held three monthly meetings with the local general practice at which most of the people who lived in the home were registered. The minutes of these meetings suggested that they were productive covering areas of common interest for the care of the people who lived in the home such as use of do not attempt cardio-pulmonary resuscitation (DNACPR) paperwork, use of medicines and medicines' reviews, transfers from hospital and protocols around recording falls. We saw the home provided regular monitoring reports to the surgery so that they could take action where a person's wellbeing required this.

The administrator told us that feedback surveys were provided to a random selection of people every six months. We looked at eight surveys which were dated June 2015, completed by relatives of people who lived at the home. There was no negative feedback. Comments included, 'staff are nice to me', 'I get privacy' and 'I have enough to eat'. This demonstrated people were provided with the opportunity to express their views about the quality of the service they received.