Fieldhouse Care Home Limited

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Inspection report

Spinners Green
Fieldhouse
Rochdale
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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?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on 2 and 3 August 2016. The service was last inspected on 8 May 2014 when we found it was meeting all the outcomes reviewed.

Fieldhouse Care Home is a purpose built home in Rochdale. It provides accommodation to people over the age of 65 who require assistance with personal care. The service is registered to accommodate 41 people. There were 37 people using the service on the day of our inspection. There is a garden area at the rear of the building.

There was no registered manager in place in the service. 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 previous registered manager had de-registered with the commission on the 17 May 2016. The service had employed a new manager who had applied to register with the commission on the 24 July 2016. The registration process was ongoing at the time of our inspection. The CQC place a limiter on this domain which cannot be assessed as anything other than requires improvement if there is no registered manager.

Prior to our inspection we reviewed our records and saw that Deprivation of Liberty Safeguards (DoLS) applications, which CQC should be made aware of, had been notified to us in a timely manner. We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority). DoLS were in place or an application had been submitted for those people who were being restricted in some way.

We spoke with the manager and three staff who were aware of the mental capacity act and what would constitute a deprivation of a person's liberty.

We saw that a mental capacity assessment had been made prior to admission. However, this was completed by the manager and there was no subsequent best interest meeting to decide if a person could consent to care and treatment. We saw that this had minimal impact on people because the service subsequently applied for a DoLS using the correct procedures. We have made a recommendation that the manager looks at professional guidance for best interest/capacity assessments prior to completing an application for a DoLS.

All other files we looked at showed people had capacity and had consented to care and treatment. We did observe staff members verbally asking for people's consent prior to undertaking personal care.

People who used the service told us they felt safe. We saw safeguarding policies and procedures were in place to support staff should they have any concerns. Staff had also received training in safeguarding and knew their responsibilities. There was also a whistle-blowing policy in place to protect staff who reported

poor practice.

Care records we looked at contained risk assessments for people who had been identified as at risk of poor nutrition or pressure ulcers. We saw these were reviewed regularly to ensure they remained relevant.

Recruitment systems and processes that were in place were robust. We saw references and identity checks were carried out as well as Disclosure and Barring Service checks.

We checked the management of medicines within the service. We found these were managed safely, policies and procedures were in place, only staff who were trained administered medicines and regular audits were undertaken.

Wheelchairs, hoists and moving and handling equipment had been serviced to ensure it was safe to use. Records showed that staff members had received training in moving and handling procedures.

All the people we spoke with told us the food was good. We checked the kitchen and found adequate supplies of fresh, fresh, tinned and dried food was available. The service had a 5* rating from environmental health.

Numerous training courses had been completed by staff members including fire safety, moving and handling, health and safety, infection control and dementia care. National Vocational Qualifications (NVQ's) were also being undertaken or had been undertaken by a number of staff members.

All the people we spoke with told us the food was good at Fieldhouse Care Home. We observed people had a choice of two main meals at lunchtime. For those people living with dementia, food was served on red plates to aid nutritional intake as best practice suggests this is effective.

We observed the lounge was lively throughout the day. People were chatting with each other or with staff members and laughter was regularly heard. Staff members took the time to sit and chat with people who used the service. Visitors were in and out of the service throughout the day.

Care records contained detailed information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs, like and dislikes and routines. However, these had not been signed by the person or their representative. Whilst this did not particularly show a person-centred approach to providing care the detailed information contained in them evidenced that there had been involvement from the person or their family members at some point.

People who used the service were encouraged to remain as independent as possible, with staff support available as and when required.

The service undertook regular quality audits to highlight any improvements needed. We saw policies and procedures were in place to guide and direct staff in their roles.

Staff members we spoke with told us they would be happy for one of their relatives to use the service. They told us there was a good culture and the manager was very supportive of them.

We saw the manager sent out surveys to people who used the service and their relatives in order to gain feedback on how the service was doing and if any improvements could be made.

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.

Staff had received training in safeguarding and were aware of their responsibilities to report any concerns. All of the staff we spoke with told us they reported any concerns to the manager.

Robust recruitment systems and processes were in place and were used by the manager when employing new staff members.

There was a policy and procedure in place for the reporting of accidents and incidents. All the staff we spoke with knew how to report any accidents that occurred within the service.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

Records we looked at showed that new staff members completed an induction when commencing employment.

Bedrooms we visited had been personalised to people's own tastes and people could bring in their own furniture if they wished. Communal areas were homely.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us that staff members were kind and caring. We observed interactions that were sensitive and respectful of people who used the service. The lounge was a hub of activity.

We were told and we observed that people's privacy and dignity

was respected by staff members. We saw staff knocked on people's doors before entering.

Care records relating to people who used the service were stored safely and securely to ensure confidentiality.

Is the service responsive?

Good

The service was responsive.

People who used the service told us there were activities available to them on a daily basis. The service had an activities co-ordinator who arranged activities within the service and outings to places such as Blackpool.

The service had a complaints procedure in place. This was also on the back of every bedroom door so that if people who used the service wished to complain they could access the correct procedure.

Prior to moving into Fieldhouse Care Home a pre-admission assessment was undertaken. This was to ensure that the service could meet the needs of people prior to them moving in.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager. The previous registered manager left their role on the 17 May 2016. The service had employed a new manager who had submitted an application to the Care Quality Commission (CQC) to become registered. A service cannot be judged as good in this domain if there is no manager registered with the CQC.

Records we looked at showed that regular meetings were held with people who used the service, relatives and staff members.

There were policies and procedures for staff to follow good practice. These were accessible for staff and provided them with guidance to undertake their role and duties.

FieldHouse Care Home Limited

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 inspection took place on the 2 and 3 August 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors on both days and an expert by experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We received this prior to our inspection and used the information to help with planning.

We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The local commissioning team responded to us and told us they had recently undertaken a quality audit at the service. They provided us with a copy of this prior to our inspection and we used this information to help with planning.

We spoke with six people who used the service and three relatives. We also spoke with three staff members, the activities coordinator, the cook, the maintenance person, the deputy manager and the manager.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for four people who used the service and the medication records for ten people. We also looked at five staff personnel files and a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living at Fieldhouse Care Home. Comments we received included, "When I first came here I was a bit depressed and could not walk. The staff here are very kind, they have helped me. This makes me feel safe here" and "I would tell staff if I felt unsafe, yes that is what I would do."

We asked one staff member what they felt may constitute a safeguarding concern. They told us, "Any abuse, maybe verbal or physical against another resident you would safeguard that then by telling the manager, maybe financial abuse from family."

Staff told us they had received training in safeguarding adults; this was confirmed by our review of staff training records. They were able to tell us of the correct action to take should they witness or suspect any abuse. One staff member told us, "I would go to my area manager or another senior or CQC." Staff were aware of their responsibilities to report poor practice and told us they were confident the manager would listen to them if they raised any concerns. The service also had two nominated safeguarding champions. These were people that had undertaken enhanced training in order to support other staff members on any issues relating to safeguarding.

The service had a safeguarding policy in place. This looked at legislation, defining abuse, preventing abuse from occurring, identifying actual or possible abuse and procedures for when abuse had occurred. This should ensure that staff felt confident when reporting or acting on any concerns. We observed that safeguarding information was also available in communal areas of the home for people who used the service, staff and visitors. This provided information on who to contact if anyone had any concerns in relation to the safety of people living at Fieldhouse Care Home.

Staff we spoke with were aware of the whistle-blowing policy. Comments we received included, "We have got a whistleblowing policy and I would be prepared to use it. I have whistle-blown in the past" and "If somebody is doing something wrong you report and I definitely would report it."

The whistle-blowing policy in place set out the principles, obligations on staff to report abuse, the commitment the service would make to the staff, investigating and dealing with allegations, dealing with interference with or victimisation of staff who have reported abuse, unjustified reporting and training.

We looked at a number of operational risk assessments that were in place in the service including, paths, windows, sluices, slips, trips and falls and hazardous substances. All showed that consideration was given to how people might be harmed, what the service was doing to reduce the risk and any further action that was needed. This should help to ensure that people who used the service, staff members and visitors were protected against any risks within the service.

Care records we looked at contained risk assessments. These were in relation to assessing risks if people had problems with certain aspects of their health, such as a history of falls, pressure ulcers or poor nutrition.

We saw these were reviewed on a regular basis to ensure they remained relevant. We also saw that those people at risk of developing pressure ulcers had their position changed on a regular basis. Positional charts we looked at showed that this was undertaken and well documented such as if the person had consented to having their position changed, result of a skin inspection and amount of carers who had supported the positional change. This should protect people from developing pressure ulcers.

We asked staff members if they knew how to report an accident/incident. One staff member told us, "I would report it to senior, if the person is on the floor you would push the button, make them safe and get someone. We have procedures we have to follow." Another staff member told us, "If a resident was to fall we would see if they are ok, stand them up and check them over of if bleeding I would get an ambulance and fill in the accident report book."

We saw the service had a policy in place for the reporting and recording of all accidents and incidents within the service. We checked the accident file and found this contained completed accident reports. These detailed the incident, the action taken and any recommendations.

During our inspection we noted a number of wheelchairs, hoists and moving and handling equipment. We saw these were maintained and serviced on a regular basis to ensure they remained safe to use. We spoke with staff about moving and handling; they told us and records confirmed they had received training in moving and handling techniques. We spoke with a senior staff member to ask if they trained staff in the use of moving and handling equipment. They told us, "No the moving and handling assessor shows us how to use them but if I thought they were doing it wrong I would show them." On the first day of our inspection moving and handling training was being held in the service for staff members.

Care records we looked at also showed that people had moving and handling care plans in place. These detailed how staff should assist people such as, sleeps in the sitting position, assisted by one or two carers, the type of slings to use and the type of hoist.

We saw that all the gas and electrical equipment had been serviced and checked within acceptable frequencies. This included electrical installations, gas appliances and portable electrical equipment. There was also a record of laundry servicing, company vehicle servicing and lift servicing. The service had a contingency plan in place in case of emergency, including electrical failure and gas failure. Control measures were in place for staff to follow.

We looked at fire safety within the service and found that personal emergency evacuation plans (PEEP's) were in place for all the people who used the service. These were detailed and included how the person might be able to get out of the building, if they used a wheelchair and if they could hear the alarm or not. This should help to ensure that people are evacuated effectively in an emergency situation.

People who used the service told us they knew what to do in the event of a fire situation. Comments we received included, "If there was a real fire we have to go outside."

We asked staff members if they had been involved in a fire drill. Comments we received included, "Yeah we have them every week", "Yeah we have them on a Friday at 3pm every week" and "Yes I worked on nights they used to do them in a morning before I left work."

During our inspection we noted evacuation slides were available at various points throughout the building and the fire evacuation procedure was displayed in the entrance. There was a fire safety policy in place which detailed what to do on discovering a fire, administrative guidelines and training.

Fire drills were undertaken on a regular basis. We saw that fire escapes, extinguishers, emergency lighting and fire systems were checked on a regular basis to ensure they were in good working order and fit for purpose. A fire risk assessment was in place.

We looked at the systems in place to ensure staff were safely recruited. We reviewed five staff personnel files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The service also had a recruitment policy in place to guide the manager on safe recruitment processes.

One person who used the service told us they required the support of staff members with personal care. They told us, "I just press my buzzer, sometimes I have to wait but they are so busy. I do not have to wait long though." Other people told us, "They look after my personal care. When I see staff I tell them I need to go to the toilet and they take me straight away", "Staff are very busy but they always have time for me" and "I have to be seen every two hours to check I am ok and my machine is working. There are always staff I can call."

We spoke with two relatives regarding staffing levels in the service. One relative told us, "There is always a member of staff around who I can speak to, staff are not rushed." Another relative told us, "They are short staffed, especially men. Staff are busy all the time but my mum gets the care she needs I know that."

Staff members we spoke with about staffing levels told us, "Mostly there is enough staff yeah. When someone is on holiday it can be short. Mornings are always busier. We have a lot of staff that pick up extra shifts", "Yeah. Morning is definitely busier but there is always enough. On call would pick shifts up" and "Yes ok. Very busy in a morning, but we always make sure they get their showers and baths."

The manager told us and we observed staffing levels on the day of our inspection consisted of one senior and six care staff, an activities co-ordinator, administrator, two housekeepers, maintenance man, a cook and kitchen assistant. The manager and acting deputy manager were also available should staff members require assistance throughout the day. Nights were covered by one senior staff and two care staff. We looked at the rotas for a three week period and found that staffing levels were similar to those on the day of our inspection. We also saw that the rota highlighted which staff members who were on duty were trained in dementia or first aid or both to ensure a suitable skill mix on a daily basis. We observed that staff members had time to sit and talk to people throughout the day without this being task led.

We reviewed the systems in place to ensure the safe administration of medicines. We saw that there were policies and procedures in place to guide staff regarding the safe handling of medicines. These provided staff members with information about the management of medicines and included information such as, the ordering of medicines, storage of medicines, disposal of medicines, covert medicines, controlled drugs, applying creams and ointments and self-medication. Patient information leaflets were available for medicines and the service had a British National Formulary (BNF) to reference for possible side effects or contra-indications. Protocols were in place for those medicines which people were prescribed on an 'as required basis'. However, they did not inform staff members what the medicine was used for. Medicine audits were undertaken on a four weekly basis with controlled drugs being audited weekly.

We saw that there was a record of the temperatures where medicines were stored, including the fridge to ensure medicines were stored to manufacturers guidelines. There was a safe system for the disposal of unused medicines. Creams that were in use had been dated when opened. This ensured that medicines that

required discarding after a period of time, such as 28 days, would be discarded appropriately and within time frames.

Appropriate arrangements were in place in relation to obtaining medicines. We saw that sufficient stocks of medication were maintained to allow continuity of treatment. When a medicine was received into the home staff recorded the quantity received onto the MAR. Staff also recorded how much medicine had been brought forward from the previous month. This helped ensure that the medicines could be accounted for as the stock of medicines could be checked against the amount recorded as being given; thereby checking that people received their medicines as prescribed.

We checked to see that controlled drugs were safely managed. We found records relating to the administration of controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) were signed by two staff members to confirm these drugs had been administered as prescribed; the practice of dual signatures is intended to protect people who used the service and staff from the risks associated with the misuse of certain medicines.

We noted all the Medication Administration Records (MAR) contained a photograph of the person for whom they were prescribed; this should help ensure medicines were given to the right person. They also contained a photograph of the tablet so that staff members could be sure the correct tablets were there. Staff members recorded the times medicines were given and all entries were clear and legible.

Some people who used the service were able to self-administer some of their medicines such as creams and inhalers. We saw that risk assessments were in place to ensure people were safe and able to administer these and these were stored safely.

All the people who used the service that we spoke with told us they felt Fieldhouse Care Home was clean. One relative told us, "When we visited the first thing I noticed was the place smelt nice and was very clean, that matters."
We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. There was an infection control policy in place to guide staff in effective hand washing, cleaning including the cleaning of spillages, the handling and disposal of clinical soiled waste, the use of protective clothing, handling and storage of specimens, disposal of sharps, storage and preparation of food.

We looked around all areas of the home and saw the bedrooms, dining room, lounges, bathrooms and toilets were clean. Our observations during the inspection showed staff used appropriate personal protective equipment (PPE) when carrying out tasks. Staff we spoke with demonstrated their awareness of their responsibilities to protect people from the risk of cross infection. Comments we received included, "Yeah I have had infection control training. My responsibilities are washing my hands before and after providing personal care and asking people if they want to wash their hands. We have gloves and aprons", "Yes I have had the training. When I am giving someone personal care; making sure I am wearing gloves and aprons" and "Yes I have had training. It is my responsibility to wear gloves." Staff had access to personal protective equipment such as gloves and aprons and we saw staff used the equipment when they needed to.

Lounges, bathrooms, toilets and people's bedrooms were clean and tidy throughout the service and we did not observe any offensive smells. There was a laundry which was sited away from food preparation areas. There were industrial type washing machines which had the facility to sluice clothes and other equipment, for example drying machines and irons to keep clothes freshly laundered. The service used colour coded bags to safely transfer and wash soiled linen. There was hand washing facilities, including hand wash and

paper towels, in strategic areas for staff to use in order to prevent the spread of infection.

Good

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 interest 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 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 that a mental capacity assessment had been made prior to admission. However, this was completed by the manager and there was no subsequent best interest meeting to decide if a person could consent to care and treatment. A 'best interest' meeting is where other professionals, and family if relevant, decide the best course of action to take to ensure the best outcome for the person using the service. We saw that this had minimal impact on people because the service subsequently applied for a DoLS using the correct procedures.

We saw a number of consent forms in place. These included personal care, photographs, medicines (including self-medication), sharing information with other relevant bodies, care and treatment, weekly/monthly weights, sharing a room and allowing visitors. We noted that one person who had capacity had signed to consent, one person's son who had the correct lasting power of attorney (LPA) in place had signed them and one person's had been signed by a relative who did not have the correct authority in place. We observed staff members verbally asking people for their consent in relation to medicines, moving and handling, personal care and activities.

We have made a recommendation that the manager looks at best practice guidance for best interest/capacity assessments prior to completing an application for a DoLS.

Staff we spoke with and records we looked at showed that staff had received training in MCA and DoLS. Staff told us, "Yes I have had that training. At the end of the day they don't realise they haven't got capacity. My responsibility is to make sure they are safe really and not abused" and "I find it confusing, we have had four different trainers and they all explain it in a different way. It's about their mental capacity and that decisions are made in their best interests."

People who used the service told us staff members had the necessary skills and knowledge to support them. Comments we received included, "They know just what I need", "Staff help us" and "Staff are all very good here."

Staff members we spoke with told us they knew people well. Comments we received included, "Very well. We get input from family and what they used to like before but when they come in we get to know them", "Very well, they are like family really. I see them more than my family. I am always talking to them" and "I know them very well."

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Fieldhouse Care Home. We spoke with the manager, staff and examined training records to see what training opportunities had been made available.

Staff members were asked about their induction. Comments we received included, "I had a week's induction. Yes it was relevant to my role", "I had my induction six years ago. I had an induction and shadowed someone for two weeks. I felt confident after a couple of days, I wasn't shy I would ask" and "I had an induction. I was here for a two week induction."

Records we looked at showed induction consisted of an introduction to the service, management systems, key policies and procedures, staff training, supervision, equal opportunities, key worker system, uniform policy, sickness, duty rotas, holiday entitlement and complaints. It also covered mandatory training in fire, health and safety, manual handling, safeguarding and infection control,

We asked staff members what training they had completed over the last 12 months. Comments we received included, "First aid, defibrillation, fire safety, all the mandatory and had end of life", "Fire safety, manual handling, Deprivation of Liberty Safeguards (DoLS), safeguarding, MCA, first aid, food hygiene including nutrition, health and safety and medicines" and "Three different dementia ones, safeguarding, DoLS, fire safety, moving and handling, infection control, first aid, health and safety, diabetes and food hygiene."

We looked at the training matrix and saw courses for staff included fire safety, moving and handling, food safety, first aid, DoLS, Mental Capacity Act (MCA), diabetes care, defibrillation, safeguarding, infection control, health and safety, palliative care, care planning, advanced dementia care, dignity in care, continence care, catheter care and National Vocational Qualifications level two and three. Some of these were mandatory courses that all staff had completed and some were optional courses for staff to further enhance their knowledge and skills if they wished or if it was recommended as part of their role.

Staff we spoke with told us they received regular supervisions and appraisals. Comments we received included, "We have supervisions, I had mine just before the previous manager left. I can bring anything up. There were a couple of things I mentioned and they rectified it. If I am not sure of anything I can always ask", "I have had supervisions and had an appraisal earlier this year. I can bring anything up" and "I have supervisions often." Records we looked at showed that staff members received supervision every six to eight weeks.

People who used the service told us they would speak to a staff member if they felt unwell. Comments we received included, "I had a cough. They called the doctor and I was given antibiotics. This was in the night", "Oh yes they will get a doctor if I need one" and "I am very confident in the staff. If I have a problem I know they will sort it."

The care records showed that people had access to external health and social care professionals such as, hospital consultants, GP's, district nurses, specialist nurses, dentists, opticians and chiropodists. This meant that the service was effective in promoting and protecting the health and well-being of people who used the service.

People who used the service told us they enjoyed the food at Fieldhouse Care Home. Comments we received included, "I asked for some tripe. They looked everywhere to try and get me some. You always get a choice of meals", "You can have more or less what you want, have as much as you want. There are plenty of vegetables", and "The food here is really good."

One relative we spoke with told us, "My mum has always suffered from constipation. This has improved since she has been here. I think this is because she is on a more balanced diet. Mum has always been a picky eater but staff tell us this is improving." Another relative told us, "Yes he enjoys the meals. No complaints."

We spoke with the cook. They told us, "People will tell us if they do not like the food. We get feedback from staff. If they do not like what is on the menu they can have something else." They also informed us that they were in the process of taking pictures of meals so that they could develop a pictorial menu to support those people living with dementia.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We looked at the kitchen and food storage areas and spoke with kitchen staff. During the lunchtime meal service during our inspection, 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. We found the lunch time meal service was a relaxed occasion. Tables were laid with linen napkins, condiments, flowers and music was playing on the radio. We observed there was a warm and friendly atmosphere with considerable chatter and laughter between people who used the service and staff members. Staff wore the correct PPE (blue apron) whilst serving meals and supporting people with eating. We saw menus were on each table so that people could choose what they wanted to eat at each meal.

We noted that people had a choice of bacon chop or lasagne for their main course, with a choice of chocolate sponge and custard or semolina for their dessert. We heard staff members asking people what they wanted and offered a selection of drinks during their meals. Tea was a choice of hot dog and onions, soup and sandwiches or cheese and biscuits. We saw that one person was given a glass of whisky as it was their birthday.

We saw that for those people who were living with dementia, their food was served on a red plate and their fluids in a red cup. Best practice guidance suggests that this supports people to identify objects easier and recognise that food is in front of them. We also saw that care plans directed staff to show those people living with dementia the two meal choices on plates so that they could visually make a choice of what they wanted to eat. This showed the service considered the needs of people living with dementia in relation to their nutritional needs.

Care records we looked at showed risk assessments were in place for those people who were at risk of choking. These included information from the speech and language therapist such as the type of diet to follow, if food needed to be pureed, the level of staff supervision required and if staff needed to encourage sips of fluid between mouthfuls. We also saw food and fluid charts were in place. These were detailed and contained information on the amount of food people had consumed, such as half or full amount. This should assist staff members to assess if people were taking adequate diet and fluids on a daily basis. Those people that were at risk of losing weight were weighed on a weekly basis.

We found the kitchen was clean and well organised with sufficient fresh, frozen, tinned and dried food stocks available. We saw records were completed in relation to temperature checks, cleaning schedules and meals served each day. The cook was aware of people's dietary needs and how to fortify foods to improve a person's nutrition.

The environmental health department had given the kitchen a five star very good rating at their last inspection. This meant the kitchen staff followed safe practices around the storage and preparation of food.

During the inspection we conducted a tour of the building. All the bedrooms we visited had been personalised to people's own tastes and people could bring in their own furniture if they wished. The communal areas were homely and there was a variety of seating to suit all tastes. Bathrooms and toilets had equipment to aid people with a disability and people had a choice of shower or bath. There was a lift to help people access all areas of the home.

Good

Is the service caring?

Our findings

All the people we spoke with told us that staff members were caring. Comments we received included, "Staff are nice. It is nice here", "The staff help me a lot" and "The staff are great." One person told us they did not like one of the staff members and had spoken with the manager regarding them. They told us "Now I ignore her."

Relatives we spoke with were highly complementary about the staff members. Comments we received included, "The staff are brilliant here. The care is there, they understand my mum. She is always beautifully dressed, her clothes are never mis-matched. The staff are easy to talk to and they listen", "We feel she is actually being cared for like we would care for her at home. I can be her daughter again and not her carer. Every place should be like this", "It was difficult at the beginning because he wanted to come with me, but staff have been very good with him. We have been married for 64 years. I can come anytime; have a meal with him if I want. His cricket friends visit him as well", "The man next door told us about this place. We were invited to look around and did not need to look anywhere else. We thought the staff were kind, you could tell they were caring just the way they were", "The first time we came here the staff were very friendly. We thought at first it was because he was new but they are still like that. When we go we do not have to worry about the care he is receiving. The staff here are very good with him" and "The feel of the place; they care for him like a human being. He loves it here. All the staff are caring, you may get the odd one but no mostly they are all good."

We spoke with staff members to ask how the felt the atmosphere of the service was. Comments we received included, "I love it, it is great. When I worked at a previous home I did not want to go to work but here I don't mind", "It is good. We all keep each other going" and "We have a nice atmosphere here. We are all happy." All of the staff members told us they would be more than happy for a loved one to use the service.

We observed that staff members' approach was calm, sensitive, respectful and valued people. They explained options and offered choices using appropriate communication skills. People appeared comfortable and confident around the staff. There was a constant 'buzz' of people chatting with each other and staff members throughout our inspection. We heard people laughing and joking with staff and each other and visitors were in and out throughout the day. The lounge was a hub of activity.

Staff members we spoke with told us what equality and diversity meant to them. They told us, "Giving them choices such as diet and religion", "We used to have a gentleman who would only eat certain things. He liked to choose what he wanted to do and eat" and "If they ever wanted to go to church we would take them. If they have food needs we would print it out and give it to the cook, for example a special diet."

We asked staff how they respected people's privacy and dignity. They told us, "I make sure I knock on their door. I personally lock the door when I am doing personal care so no one can enter" and "Make sure personal care is done behind closed door."

Throughout our inspection we observed staff respected people's privacy and dignity. We saw they knocked

on people's door and waited for an answer before entering and personal care was delivered in private with doors closed.

Care records were stored securely; this helped to ensure that the confidentiality of people who used the service was maintained.

We spoke to staff about confidentiality and what they felt it meant to them. They told us, "Not to discuss things on social media or outside of work", "If we know something about them I would not discuss it in front of someone else. I wouldn't put anything on social media. When I leave work I do not talk about it" and "We have a handover and if anything is confidential we will tell them. We have a really strict policy here."

We looked at how people were supported to remain independent. One relative told us, "Dad is encouraged to get up and walk around. They keep him independent for as long as possible." Staff we spoke with told us, "You've just got to have patience. Allow them to do things. They might be a lot slower but let them do it. One person is not very good at shaving but I let him do it himself first and then I tidy it up for him", "A lot of them I let choose their own clothes, if they want a wash and everything else" and "You can tell by their body language if they don't like things and you just tend to learn. I encourage them to do things for themselves if they can."

We saw a poster in communal areas regarding contact details of other services that could provide advocacy support for those people who may need it. This included the carer's resource centre in Rochdale, Rochdale and district MIND and Age Concern. This would support people who did not have a relative or friend or if they felt the manager could not assist them.

The manager informed us that there was no one in the service who was currently receiving end of life care. We saw that some staff had received training in palliative care and the service had been awarded a plaque – "Palliative Care Education Passport 2016 Making Every Moment Count" in recognition of the training staff had undertaken. From the records we looked at we saw one person had discussed their end of life wishes and this was documented.

Good

Is the service responsive?

Our findings

People who used the service told us activities were available every day. One person told us, "I never get fed up because there is always something to do. There is bingo, horse racing, we sing and other things." One relative told us, "They took mum out on a trip and we have been told she was up dancing with the manager, we could not believe it. It was good to hear."

Records we looked at showed a chart was in place to identify what activities each person had joined in with daily. We saw that activities undertaken for two people included special requirement morning (for those people who were living with dementia or required enhanced support), hairdressers, nail care, bingo, quiz and horse racing afternoon.

We asked staff what activities were on offer for people who used the service. They told us, "In the afternoon we get involved with quizzes and singers every now and again. There is always something going on", "Yeah more so now we have [name of manager]. We are pleased we are getting more time to talk to them and get to know them", "We do when the bus is right and fixed. We go to Hollingworth lake, shopping, Blackpool, pub and meals out (especially around Christmas) and white house garden centre" and "I think they go to Blackpool in the summer. They do go out shopping."

We saw that people had their own activity plans. Tuesday, Wednesday and Friday morning was personal time for people with special requirements. They looked at past hobbies, interest and read the morning paper. We spoke with the activities co-ordinator. They told us, "On Friday's we have memory reminiscence in the lounge with memory cards and a 'feely box'. We also have exercise with a ball and hoop." This was in addition to the other activities we had already seen. We also saw that the activities co-ordinator had recently attended a service user meeting where they had made several suggestions for activities and told people that everything would be put into a newsletter that would be available for everyone. We observed the activities co-ordinator was energetic and enthusiastic about their role. It was clear from our observations that people who used the service responded well to them.

We observed there was a library of books in the entrance that people could help themselves to. There was a sign up in communal areas advertising a summer fayre and raffle tickets being on sale. On the day of our inspection there was a 'tuck shop'. People could buy sweets, chocolate, crisps and toiletries. There was a poster advertising a memory well-being café in Rochdale and a poster advertising health, fitness and well-being lessons being undertaken in the service.

People's religious needs had been considered in care plans. Staff members told us, "We have a minister that comes in on a Sunday" and "A minister comes in at weekends. We have a choir coming in from a local school and the Salvation Army come in as well." Records we looked at confirmed what staff had told us.

Records we looked at showed that prior to moving into Fieldhouse Care Home a pre-admission assessment was undertaken. This looked at the background to the referral, medical history, prescribed medicines, allergies, daily living abilities, oral hygiene, night care, diet and nutrition, social inclusion, falls risk, smoking,

religion and faith requirements. This provided the registered manager and staff with the information required to assess if Fieldhouse Care Home could meet the needs of people being referred to the service prior to them moving in.

We looked at the care records for four people who used the service. The care records contained detailed information to guide staff on the care and support to be provided. There was good information about the person's social and personal care needs. People's likes, dislikes, preferences and routines had been incorporated into their care plans. We saw the care records were reviewed regularly to ensure the information reflected the person's current support needs. Care plans had not been signed by the person or their representative and there was no evidence that people were involved in reviews. Whilst this did not particularly show a person-centred approach to providing care the detailed information contained in them evidenced that there had been involvement from the person or their family members at some point.

All the relatives we spoke with told us they had signed documents that were probably a care plan. Staff members we spoke with told us, "We can access care plans and read them. When we get a new resident we read the pre-admission assessment and then when the care plans have been done we look at them", "Yes I write the care plans. I have only just started. I am being supported to know what to write" and "I don't write care plans the senior's do them but I look at them. I look at them to find out what type of sling to use."

We asked staff members how they ensured they gave people who used the service choices. Comments we received included, "There are some that are not morning people. One in particular will get up at dead on 9am. There is someone who can stay in their room if they want. There is always a choice of meal and a choice of having a bath or shower" and "People get a choice of food and drinks. When I get people up I give them a choice of what to wear. There are a few gentlemen that get washed and dressed and like to lie back on their bed."

Staff members we spoke with told us they had handovers on a daily basis. They told us, "We have handovers. One in a morning and then one at 2pm. Basically every shift change" and "We have handovers, they are especially important if you have been on holiday so you can find out if anything has changed." We saw that care records contained a communication sheet where staff made a log if they had made contact with family or friends.

We saw the service complaints procedure was on the back of people's bedrooms doors. This should ensure that people who used the service knew how to complain should they need to. The service had a complaints policy in place. This covered verbal complaint's, written complaints, investigating complaints, follow up action and training for staff members. We saw that four concerns had been received since 2014. All of which had been dealt with and action taken to address the concerns such as the involvement of the GP to review medicines.

We asked staff members how they would respond if someone complained to them. They told us, "I have not personally had to deal with a complaint here. I would speak to a senior first. If it was a minor thing I would deal with it but if not I would take it to the senior" and "If a senior could not deal with it then I would go to the deputy manager and if I needed to go further I would do."

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. 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 previous registered manager left their role on the 17 May 2016. The service had employed a new manager who had submitted an application to the Care Quality Commission (CQC) to become registered. The registration process was ongoing at the time of our inspection. The CQC place a limiter on this domain which cannot be assessed as anything other than requires improvement if there is no registered manager.

All the people we spoke with told us they liked the new manager. One relative we spoke with told us, "I have seen the change here since the new manager came. It was good before but now it seems more professional. His door is always open, you can talk to him."

We asked staff members if they felt the manager and management team were approachable. Comments we received included, "Yes he is very nice. He has an open door policy. I also feel supported from other staff", "Yes I do now. Definitely more so now, all the seniors and especially [name of manager]. He has his door open and his blinds are always open. They are all approachable and fair" and "Yes definitely."

The manager told us they felt supported in their new role by the provider. They told us "I can't praise [name of provider] enough, she has been extremely supportive. She has been here two or three times a week but she calls in most mornings to make sure everything is ok. She has told me 'I am only at the end of a phone no matter what it is or what time it is; no question is a silly question'. She has been really supportive. To step into another person's shoes is a big thing, I would work my backside off to make this place how it should be." We found the manager was passionate about his role and was very approachable throughout our inspection.

We asked the manager how they ensured the needs of people who used the service were met. They told us, "I constantly monitor things, constantly monitor the care plans and risk assessments, ensure reviews are regularly done, have meetings with family members, quality assurance, a lot of it is through auditing and I am here every day. I do pop in unannounced on a Saturday and Sunday for a couple of hours. I constantly walk round for the overview of what is going on in the home. The deputy and seniors know my expectations about the care people should be getting."

The quality assurance systems in place within the service were sufficiently robust to identify areas for improvement. The audits we looked at included, care plans, bedroom checks, cleanliness, kitchen, medicines, infection control, finances, hoists, slings, nurse call system, risk assessments, weights and window restrictors. All of which were undertaken on a regular basis.

There were policies and procedures for staff to follow good practice. We looked at several policies and procedures which included safeguarding, whistleblowing, fire evacuation, medicines, infection control,

recruitment, confidentiality, MCA, DoLS and complaints. These were accessible for staff and provided them with guidance to undertake their role and duties.

The service had received a number of thank you cards. We saw comments included, "Thank you so much for taking care of [relative name]. We appreciate all the care and kindness", "To all the wonderful staff at Fieldhouse. Thank you", "Thank you for all the care you gave to our lovely [name of relative] and for making her final years safe. Please give [name of staff member] our special thanks for treating her with dignity and respect and for taking her to hospital", "Sincere thanks for all the wonderful care and love you gave to [name of relative]. We would like to express our gratitude for the support you have given to us" and "[Name of person] really appreciated everything at the home from companionship, the entertainment, excellent food to the kind care given by staff. Thanks."

We saw that regular staff meetings were held in the service. Topics for discussion included, duty of candour (this was explained to staff), CQC inspections (Discussed the five domains and how staff should relate their work to each domain), infection control, nutrition, the use of red crockery to improve nutritional intake, menus, confidentiality, supervisions, rotas, marketing the service and professionalism. We saw that there was a record of which staff members had attended and staff had signed to confirm they had read the minutes.

We asked the manager how they ensured staff felt supported in their roles. They told us, "I always go in on handovers in the morning and any issues they raise they know I am there to support them, I have an open door if there is something you want to discuss. I would rather deal with something there and then. [Name of deputy manager] has been very supportive."

Staff told us they were able to bring up topics for discussion in staff meetings. Comments we received included, "Yeah you can do and I just don't shut up. We are encouraged to speak to people now. It is a lot more relaxed now" and "We all get asked at the end if there is anything we want to bring up."

People we spoke with told us they had meetings in the service. One person stated, "We have a meeting where we can say how we feel or what we would like to do." Staff told us, "We respond to patient's needs and if we want to change anything we will not do this unless we have attended the residents meeting, to gain their views on any changes we would like to make."

Records we looked at showed the last service user and relatives meeting was held in June 2016. Twelve people who used the service and four family members attended. We saw items for discussion included, activities, nutritional choices, menu choices, cleanliness, the environment, introduction of the new manager, days out and input from people and their family members. The new manager had provided people with an overview of his background and made a promise to ensure there was the highest level of personalised care at Fieldhouse Care Home.

Surveys had been sent out in June 2016 to people who used the service and relatives. On the day of our inspection six had been returned from people who used the service. We looked at these and found all the people who had responded thought the catering and food was good or excellent. All of them thought the personal care and support they received was good and all of them thought the manager was good or excellent.

We saw seven surveys had been returned from relatives. Information we gathered from these included; all said their first impressions of the service were excellent. Five people said the care was excellent and four said it was good. All seven said that the staff were excellent at welcoming them. Four people said the meals were

excellent, one said it was good and two said it was average with a comment "It is always difficult to please [name of relative] or get her to eat but staff try their best. Six people thought the laundry service was excellent and one thought it was good. We saw some people had made comments such as, "Very happy with [name of relative] care", "You get top marks", "No smells, the home is always clean and they get clean clothes every day. I have always felt more than welcome. The home is peaceful and relaxed", "The staff are always kind and caring" and "The only negative is sometimes the food is not hot. On a positive note staff are brilliant and even when they are under pressure they are always pleasant and welcoming."

There was a service user guide in place within the service. This contained information such as, staffing levels, values, personal care and support, meetings with families and relatives, complaints, surveys and the contact numbers for CQC and Rochdale Safeguarding team for people to refer to if they needed to.

We asked the manager what the key challenges for the service had been. They told us, "Everyone was very flat as the home was quite empty and staff were worried about their jobs. The atmosphere wasn't very good. I have been working on the atmosphere, getting on top of policies and procedures and filling of the beds." When asked what the key achievements of the service had been, they told us, "Getting people into the beds and changing the atmosphere. I don't just see it as filling a bed I see it as providing a home for someone and the morale of the staff has improved greatly."

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 7 HSCA RA Regulations 2014 Requirements relating to registered managers The service did not have a person registered as manager with the Care Quality Commission.