Field House (EYE) Ltd

Field House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Field House is registered to provide accommodation and personal care for up to 49 people, some of whom live with dementia. The home is located in a village and close to the city of Peterborough. When we visited there were 33 people living at the home. The location is also registered to provide personal care for people living at home. There were four people receiving this service when we visited.

The inspection took place on 3 May 2016 and was unannounced and carried out by one inspector.

A registered manager was in post when we inspected the home and had been registered since 2011. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safe as staff were knowledgeable about reporting any abuse. The home was clean and a comfortable place for people to live. There were a sufficient number of staff employed and recruitment procedures ensured that only suitable staff were employed. Arrangements were in place to ensure that people were protected with the safe management of their medicines.

The CQC is required by law to monitor the Mental Capacity Act [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was acting in accordance with the requirements of the MCA so that people had their rights protected by the law. Assessments were in place to determine if people had the capacity to make decisions in relation to their care. When people were assessed to lack capacity, their care was provided in their best interests. Authorised DoLS were in place and the conditions of the in-date DoLS were being followed.

Staff were trained, supported and supervised to do their job.

People were supported to access a range of health care professionals. Health risk assessments were in place to ensure that people were supported to maintain their health. People were provided with adequate amounts of food and drink to meet their individual likes and nutritional and hydration needs.

People's privacy and dignity were respected and their care was provided in a caring and attentive way.

People's hobbies and interests had been identified and a range of activities supported people with these. People's care records and risk assessments were kept up-to-date. A complaints procedure was in place and staff were aware of how to support people if they wanted to raise a concern or complaint.

The provider had quality assurance processes and procedures in place to improve, if needed, the quality and safety of people's support and care.

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 were kept safe from the risk of harm by staff who were suitable and trained in keeping people safe.

People's needs were met by sufficient staff.

People were supported to take their medicines as prescribed by staff who were trained and assessed to be safe to do this.

Is the service effective?

Good

The service was effective.

Staff were trained, supported and supervised to do their job.

The provider was acting in accordance with the requirements of the Mental Capacity Act 2005.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by attentive and kind staff.

People were enabled to maintain contact with their relatives and forge new friendships.

Advocacy services were available to support people in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People were supported to engage in activities, hobbies and interests that were meaningful to them.

Staff had access to up-to-date guidance to provide people with care to meet their individual needs.

Is the service well-led?

Good

The service was well-led.

Staff and people were enabled to contribute in the running of the home.

Systems were in place to ensure that people were in receipt of safe care.

There was an open culture which welcomed links with the local community.

Field House

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 3 May 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we received information from a local contracts and placement officer to help with the planning of our inspection. We also looked at all of the information that we had about the home. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with seven people who used the service and four relatives. We also spoke with a community nurse; the registered manager; the head of care; one senior carer; two members of care staff; the activities co-ordinator; the administrator; a member of the catering staff and the maintenance man.

We looked at three people's care records and records in relation to the management of the service and the management of staff. We observed people's care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

One person also said that they felt safe because of the security of the premises. They also said that they felt safer living at Field House compared to when they lived at home. They said, "It's 24-hour care here. My two boys [relatives] can go home [and not worry], knowing that I am safe." One relative wrote to the provider and said, "It's so reassuring to know that [family member] is in a safe place where [family member] seems to be happy." Other people told us that they felt safe because of how they were treated. The community nurse told us that they had no concerns about how staff treated people.

Staff were aware of their roles and responsibilities in protecting people from the risk of harm. They were able to describe the types of harm and the correct reporting procedures in the event any person was placed at the risk of harm. In addition, members of care staff were knowledgeable in identifying the signs that people can show if they are being harmed. One senior member of care staff said, "The person could be crying. Or they could have [unexplained] bruising." The head of care said, "You get to know how people are as you interact with them every day. You would notice something unusual [if they were being harmed]. For example, they could be withdrawn or another change in their behaviour."

One person told us that their room was cleaned every week and one relative told us that their family member's room was cleaned "every day." The premises were clean and we saw that staff quickly mopped up spillages of a drink and swept up broken pieces as a result of a dropped drinking glass. Toilets and bathing areas were clean and people and staff had access to dispensable soap and disposable hand towels to maintain their hand hygiene. Signs were above communal hand wash basins to remind people and staff of the correct hand washing practices. We heard a member of staff remind a person to wash their hands after using the toilet. Staff and visitors had access to hand gel to maintain their hand hygiene as part of an infection control measure. We saw a member of senior care staff handle people's medicines in a hygienic way; this was by using non-touch techniques and offering people their tablets on a spoon. Relatives' views about the cleanliness and freshness of the home were obtained in the provider's survey; the comments made about the cleanliness of the home were 'clean' or 'very clean' with 'no detectable odours'.

The maintenance man described the system in place to ensure that wheelchairs were kept both clean and in safe working order. One member of care staff demonstrated their knowledge in relation to this wheelchair maintenance system. This included recording any issues in the maintenance book for remedial action to be taken by the appropriate members of ancillary staff. Wheelchairs were clean and in good working order with appropriate foot plates and brakes.

Fire prevention measures were in place which included staff fire training and the activation of the fire alarm on a weekly basis. In addition, there was discreet information on bedroom doors: this was regarding people's individual requirements for staff to help them to a place of safety in the event of an outbreak of a fire.

There were recruitment procedures in place to ensure that only suitable staff were employed to look after people using the services. One senior member of care staff described their recruitment experience and said,

"I filled out an application form; there was a DBS [Disclosure and Barring Service] check; proof of ID [identification] and a reference from my previous employer." The head of care also told us that they too had undergone such a recruitment procedure and that this was before they were allowed to start their employment.

People said that there was always enough staff to meet their individual needs. One person said, "There's plenty of staff for me." They also told us that they did not need to wait for staff to respond to their call for assistance. We timed staff response times to people's ringing call bells and these were answered within less than two minutes. One relative told us that their family member received care at home by a consistent team of staff who were punctual and stayed the allocated time, with no missed calls. They said, "It is [staff roster] strictly kept to four staff. All four come regularly. We're happy as you know who is coming into your own home. The staff arrive on time and there are always two people [care staff] for the one hour."

Relatives and the community nurse told us that, when they visited the home, there were enough staff. One relative said, "There seems to be enough staff when we come." One person said, "I never have to wait at night for staff [to come]." Members of staff told us that there was always enough staff, which included night duty, when two waking care staff were rostered to work. One member of care staff said, "There are about five people who need [during the night] 'double ups' [two staff members]." They told us that if another person was to call for assistance, whilst they were working as a 'double up', one member of care staff would leave, from what they were doing, and assess the urgency of the situation. They also told us that the registered manager and representative of the registered provider were on-call and were available if needed. The registered manager advised us that they were "not often" called out as there were enough staff on night duty to meet people's individual needs. However, they told us that they listened to what staff had to say about staffing numbers and had taken action to increase the numbers of catering and care staff. The member of catering staff told us that other members of staff helped them with their work, if this was needed, which included washing up. They also told us that extra care staff started work at 11:00am to help with the number of people who needed assistance with their eating their lunch. We saw people were looked after by staff who were not rushed and provided people with individual care, which included eating their lunch time meal.

There were measures in place to cover staff absences or leave. The registered manager said, "Agency staff are not used. With the [permanent] staff, who live locally, they help each other out."

Assessments were in place to manage people's risks. These included risks of falling and development of pressure ulcers. One member of care staff told us the reason they walked by the side of a person was to reduce their risk of falling. The head of care said, "We do risk assessments as required and update these if there have been any changes in their [person's] needs. We put measures in place to control the risk; for example; with the risk of [unintentional] weight loss we encourage fortified food and refer people to the dietician."

People were satisfied with how their medicines were managed. One person said, "I have a tablet every day. Once a week I get a small tablet and I know I have to sit upright when I've taken it. I have to wait for half an hour before I have my breakfast." Another person said, "I'm getting a lot of tablets. They help relieve my pain." We saw another person being offered to take their prescribed tablets, one at a time on a spoon, and were checked that they had safely swallowed them with a drink of water.

The community nurse said that they believed people had their medicines as prescribed; medication administration records [MARs] confirmed that people had taken their medicines as prescribed. Audits were carried out to monitor stock levels of people's medicines and the accuracy of completion of MARs. One member of senior care staff told us that there were disciplinary procedures in place. They said, "If there are

any repeated errors of recording [in the MARs] we report it to [name of registered manager] and disciplinary action could be taken."

Staff who were responsible for the management of people's medicines were trained and assessed to be competent. On the day of our visit an in-house trainer was providing senior care staff with refresher training in the management of people's medicines. Storage of people's medicines was satisfactory with arrangements in place to improve the facilities to store people's medicines in the new part of the home.

Good

Is the service effective?

Our findings

Staff members told us that they had the training to do their job. This included looking after people living with dementia, moving and handling, fire training and care of people's continence aids [urinary catheters]. Staff were able to demonstrate how their learning was applied. The activities co-ordinator said about people living with dementia, "If you put effort in, it's all about 'conversation'. Even if they live in their own world. They still know what's going on. They [people] can feel you and you can get amazing things from them."

Members of staff also said that they had the support to do their job and this was provided on both an informal and formal basis. The head of care said, "I get supervision from time-to-time with the [registered] manager. The last one was one or two weeks ago. We do it when it is required. If I have any queries of problems [in the interim] [name of registered manager] is here to answer any queries or give support." One senior member of care staff said, "I had my one-to-one [supervision] last Monday. It's every month. We discussed about my well-being. Any suggestions I may have about improving people's care and any training needs I have." There was a plan in place which had scheduled dates for staff to attend future one-to-one supervision.

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. We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's mental capacity was assessed and authorised, in-date Deprivation of Liberty Safeguards [DoLS] applications were in place: these were for those people who lacked mental capacity and who would be unsafe to live without constant supervision. Some of the people were assessed to be at risk of falls: one of the measures taken was to monitor their whereabouts by means of alarmed pressure mats on their bedroom floors. It was unclear if this monitoring equipment had been considered when people's DoLS applications were authorised by the appropriate authorities. The registered manager advised us that they would take action to clarify this matter with identified employees of the authorising DoLS agencies. When people lacked mental capacity to make decisions about their end-of-life treatment, medical practitioners consulted people's family members in this process. This was to ensure that people's end-of-life care was in the person's best interest.

Some staff had attended training in the application of the MCA. One senior member of care staff said, "The MCA means that people living with dementia are supported to make decisions. Their mental capacity is assessed at the pre-admission stage and this involves people's relatives." Arrangements were in place for staff to attend training in the application of the MCA.

People said that they liked the food and had a choice of what they wanted to eat. One person said, "I enjoy the food and they [staff] give me extra. I am putting on weight." We heard another person asking for toast for their breakfast and their request was catered for. One relative said that their family member was given choices of what they wanted to eat and we saw that their choice of creamed potatoes and tomatoes was provided. People had cold and hot drinks and these were placed within their reach. During mid-morning people were offered biscuits and fruit to eat. When people needed help to eat and drink, they were given the encouragement and support with these needs. Cultural and specialist diets were catered for, which included vegetarian and soft food diets.

Menus were presented in both pictorial and written formats. The member of catering staff told us that they knew what people's individual dietary needs and preferences were. They said, "I go around and ask people what they want to eat. Sometimes the families give this information. People can have whatever they want. We have three people who have pureed food and there are people who also have fortified food. We do [make] milkshakes; give extra puddings. We also put cream into mashed biscuits; add cream and butter to mashed potatoes and we use powdered milk."

People's weights were monitored and the frequency of this monitoring was based on people's reviewed and up-to-date nutritional risk assessments. Dieticians' advice was obtained and followed when a person was assessed to be at a high risk of undernourishment. People's weights were stable and some people, who had experienced unintentional weight loss, had gained an increase in weight, in response to the effective nutritional measures taken.

We received positive comments from people's relatives in respect of their family members' health. One relative said, "My daughter said [family member] looks five years younger since being here. [Family member] is more alert. Their swollen legs are now back to normal and staff make sure [family member] has their legs raised. They [staff] have kept on top of [family member's] catheter care. Since [family member] has been here [family member] has not had an [urine] infection. [Family member] has been here about six to seven weeks. In that short time we've seen such a change [in family member's] health." One person said that they had no need to see a GP but said, "They [staff] come around and ask if you want to see one." The community nurse told us that care staff referred people to the GP or their nursing service without any delay. Other health care professionals supported people with their individual health care needs; these included speech and language and occupational therapists and community psychiatric nurses.

Each morning people were encouraged to take part in armchair exercises to stretch and bend their muscles and joints. One person said that the morning exercise "went well." Another person told us that they enjoyed the exercise as this had helped them remain physically independent with their personal care. A third person said, "I'm getting exercise and I'm beginning to walk again."

The activities co-ordinator said, "Exercise is good for people living with dementia. It's about improving their life style." They gave an example of a person living with dementia who became less agitated when they took part in the armchair exercises. Other diversional techniques were used to help people with mental health needs become less anxious or more settled. This included the use of singing. One person's care records demonstrated that the use of diversional techniques worked most of the time and, as a result, they required less prescribed medication to calm their anxieties.

Good

Is the service caring?

Our findings

One relative told us that, due to the consistency of staff, coming into their community-based home, this had helped forge a good trusting relationship between them and the staff members. Other relatives had positive comments to make about the staff. One relative had written to the provider and said, "Everyone has been so helpful." Another relative wrote, "Field House has made a good impression on us. It is clean, well run with caring staff." People also told us that the staff were kind. One person said, "The carers [staff] are very good. I just can't fault them." We saw staff were attentive to people's needs and this included taking time to help them with food, drink and taking their prescribed medicines.

People were enabled to maintain contact with members of their families. One person said, "Every day I get visitors." One relative told us that they and other relatives visited their family member most days. We saw that some people had made friends with each other. This fostering of relationships was encouraged during activities: we saw some people sitting outside in the sunshine, while having their mid-morning drink and snacks, and talking with each other. We saw one person helping another person to put their footwear on; we also saw a second person offer another person a tissue to wipe their nose.

People's comfort was maintained and promoted. One person told us that staff were "always checking" them to see if they were alright and added, "I feel part of the home." We saw a senior member of care staff place a blanket over a person's knees to help them keep warm. We also saw a member of care staff adjust a person's cushion to make them feel more comfortable while sitting in their armchair.

Staff offered people choices about where they wanted to sit and one person said that they chose to sit with other people to eat their meals. People were offered choices of when they wanted to get up and go to bed and people told us that their choice was respected. One person said, "I got up about eight o'clock. I was happy with getting up then." Two relatives told us that staff respected their family members' choices of how they wanted to be looked after.

The premises maximised people's privacy and dignity: the majority of bedrooms were for single occupancy only. The registered manager advised us that there were three shared rooms and the sharing was part of an arranged agreement with people and their relatives. Toilet and bathing facilities were provided with lockable doors; people were provided with personal care behind closed doors. In the provider's survey, people had completed their questionnaires and all said that their privacy and dignity were respected. Opportunities were available for people to have their own key to their room to maximise their privacy. Closed circuit monitoring equipment was in communal spaces only: the registered manager told us that people and their relatives were aware of this security measure and had received no concerns.

People told us that the way they preferred to have their personal care provided was respected. One person said that they always liked and had a shower. They added that they were always supported by a female carer with this and "never a man." One person told us that they were allowed to wear their clothes which were in keeping with their cultural identity. One relative told us that they were satisfied with how their family member's personal care was provided: they said, "[Family member] always looks clean and well-kempt."

Members of care staff demonstrated an understanding of the principles of caring for people. The head of care said, "I enjoy my work. It's looking after people and respecting their privacy, dignity and choice. Respecting their [cultural and religious] beliefs." The activities co-ordinator told us that they involved people in making choices about what hobbies or interests they would like to take part in. They said, "I did talk to everyone. What they like to do. What they don't like to do."

General advocacy services were used to support people in making decisions about their care and support. Advocacy services are organisations that have people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's needs were assessed before receiving care to ensure the staff were able to meet the prospective person's needs. One person said that they knew the home as they had previously lived in the same neighbourhood and knew some of the staff. One relative told us that before their family member received care at home, they were enabled to contribute to the assessment process. They said, "We put it [care plan proposal] to them [provider] what we needed and we got it." They also told us that the care had helped them remain their family member's main carer and had kept them living together at home. The head of care told us that people's care plans were based on pre-admission information. They added that new care plans developed over a short period of time, when the person's needs were being continually assessed and reviewed. They said, "Once we get to know them [people] after five weeks we then complete a full care plan."

Relatives and people told us that staff knew them, people, as individuals and we saw that this was the case. We saw members of staff, which included the registered manager and maintenance member of staff, talk to people about their interests and what they were able to do. We also saw that members of care staff spoke with people in the way that they were able to understand. This included the use of people's first language.

People were supported to follow their spiritual and religious beliefs. One person said, "My [representative of religious organisation] comes once a fortnight." They told us that they were looking forward to attending a religious service in the local community. Another person told us that they enjoyed going out once a week to attend a religious organisation to practice their faith and meet people of the same beliefs and religious practices.

Care records and risk assessments were kept up-to-date and reviewed each month or sooner, with the person or their relatives. One relative wrote to the provider and said, "Many thanks for my [relative's] care plan update." The head of care described the care plan review process: they said, "I would sit with the person and then we would go through every single detail of the care plan. Monthly or when it is required. [Name of person] was happy for their relatives to be sent a copy of [person's] care file." One relative said that they had attended reviews of their family member's care. They told us that a wheelchair was on order as part of the outcome of the most recent review of their family member's care.

Reviews carried out also included those for people's hobbies and interests. The activities co-ordinator said, "I reviewed what people liked to do. I adapted what they were able to do according to their physical abilities." They gave an example of improving a person's independence in eating; this was with the introduction of hand exercises and sensory stimulation to increase the person's hand dexterity and sensation to touch.

The activities co-ordinator told us that each morning people were encouraged to take part in armchair exercises. One person said that this had helped them increase their stamina and confidence. They also told us that the exercise and encouragement from staff had helped them to regain their level of mobility. The registered manager gave an example of another person's improvement in their ability to walk. We saw the

person was able to independently walk.

People were offered a range of other recreational activities to take part in and meet their individual needs. One person said, "I never get bored. I like to knit and read." The activities co-ordinator described how they were able to engage people who were living with dementia. They said, "They [people] weren't joining in with the exercises but I've found that they joined in with my counting [during the exercise]. Now I have found they have [fully] joined in." Two relatives told us that their family members had opportunities to take part in the recreational activities. One relative said, "They [staff] are always asking if [family member] wants to do anything. [Family member] did make Easter cards and enjoyed doing that."

People knew who to talk to if they wanted to raise a concern or complaint. One person said, "I'd tell the boss." People said that they were satisfied with their care and had no cause to raise a concern or complaint. One relative of a person, who received care at home, said, "I've got a whole book of information if I need to speak with [name of registered manager]." Staff members were aware of how to support people with following the provider's complaints procedure. This included listening to what the person was saying and reporting their concerns for the registered manager to deal with. The record of complaints showed that there had been no complaints made to the provider within the last twelve months. The registered manager said, "We don't have complaints because we are always communicating with people and relatives."

Good

Is the service well-led?

Our findings

People knew who the registered manager was and knew their name. We saw the registered manager knew individual people and engaged with them in a social and kind way. We also saw that they supported staff in looking after people; this included helping people with eating and drinking and checking in a new delivery of people's medicines. Relatives told us that the registered manager was always available and often helped staff look after people. Members of staff had positive comments about the registered manager; one member of care staff described the registered manager as "fantastic." A member of senior care staff said, "[Name of registered manager] helps us a lot."

We received notifications as required which demonstrated that the registered manager was aware of their legal responsibilities to do so. This included, for example, notifications to inform of us when people's DoLS applications were authorised.

Following our last inspection, which we carried out during July 2015, the provider had developed an action plan and this showed that remedial action was taken to improve the standard and quality of people's care. The registered manager demonstrated an open and transparent leadership style as they said, "We look at each inspection's suggestions positively and listen to people's views and take these on board. To better ourselves. To better the service as nothing is perfect."

Staff had opportunities to make suggestions during their one-to-one supervision and during staff meetings; members of staff told us that they felt supported and listened to. One member of care staff said, "If we have any problems, such as any areas we feel we need to improve, we can talk to [name of registered manager]. I feel listened to. Lots of things are changing and have improved. For example record keeping." They also told us that the registered manager asked staff members about the numbers of staff needed in response to people's changed needs.

Minutes of staff meetings showed that staff were reminded of their roles and responsibilities in providing people with safe care. This included maintaining the cleanliness of the home and ensuring that people's records were kept up-to-date. People were also present at these meetings and the registered manager advised us that people were given opportunities to make suggestions and comments about the running of the home. An example of this was the introduction of pasta to the menus and a take-away fish and chip tea every week from a local provider. One person told us that they had a fish and chip supper the day before our inspection. Menus demonstrated that people's suggestions were valued.

The provider was carrying out surveys to obtain people's and their relative's views about the standard and quality of the service provided. The results of the surveys had yet to be collated and analysed to assess for any emerging trends or themes. However, there were positive comments found in those surveys returned. Based on previous comments, remedial action was taken to increase the number of activity co-ordinator hours worked from part to full-time and to increase the number of catering staff hours.

Other quality assurance measures included audits for people's medicines and their care plans and remedial

actions were taken in response to any deficiencies found. This included, for example, senior members of care staff communicating with a local pharmacist and GP to improve the management of people's medicines.

Field House is located in a village where there are local shops, schools and religious organisations. Other community links included Peterborough colleges. People were enabled to take part in events run by these community organisations which included eating and drinking out; practising their chosen religious faith and being entertained by local school children. The registered manager told us that pre-medical students had helped with voluntary work at Field House, before going to university. They said that they welcomed more volunteers and visits from local school children and added, "I love that because young people have so much to offer."

Members of care staff knew about the provider's whistle blowing policy and were aware of their roles and responsibilities in following this. They also told us that they had no reservations in blowing the whistle on poor practice that posed a risk of harm to people they looked after.