Stroud Care Services Limited

Fieldview

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We announced the start of our inspection to the provider 24 hours before we visited. We did this to ensure that key members of staff would be available for the inspection. Fieldview is registered to provide accommodation for up to seven people in the care home and also provides a personal care service (domiciliary care) to people who live in a shared house and one other person who lives in their own home in the local vicinity. For the purposes of this report we have referred to a community based service (people receive support in their own home) and have used Fieldview when referring to the care home. Both services care for people who have enduring mental health and learning disabilities

At the time of the inspection a community based service was provided to seven people, six who lived in a shared house and one other person who lived in their own home. This service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting

Summary of findings

the requirements of the law; as does the provider. 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.

Fieldview is a large detached property within walking distance of Stonehouse, Gloucestershire and the accommodation is spread over three floors. Fieldview is managed by another registered manager who has recently been registered by the Care Quality Commission. There were six people in residence in the care home.

Improvements need to be made with the way in which the staff apply the principles of the Mental Capacity Act 2005 and the associated code of practice. The mental capacity assessments that had been completed were incomplete. This may mean that issues around consent were not considered and best interest decisions not recorded correctly.

People were provided with care and support that met their care and support needs and took account of their individual choices and preferences. However care planning documentation was not completely accurate in respect of do not resuscitate decisions. This may mean that people could be provided with care or treatment that was not agreed.

The systems to assess and monitor the quality and safety of both services were not effectively operated because no action was taken as a result of any findings. No action plans were put in place to drive forward any improvements that had been identified. The service did not gather feedback from families and health and social care professionals about the service.

People from both services said they felt safe and the staff helped them to keep safe. One person in the shared house said they all got on well together. Staff received safeguarding adults training and knew what to do if concerns were raised. Where staff were handling people's money, there were records in place to account for money spent.

Staff recruitment procedures ensured that unsuitable workers were not employed to work in either service. Staff were well trained and were supported to do their jobs effectively. There were sufficient numbers of staff to meet the care and support needs of people.

Risks were well managed on the whole. However, an environmental risk assessment of the homes of those people support by the community based service had not been completed. This shortfall was highlighted when we inspected in July 2014. By the end of the inspection the registered manager had located a blank document and gave an undertaking to complete the task promptly.

Medicines were well managed. Staff received training in order to administer medicines. People supported by the community based service were assessed to determine the level of support they needed with their medicines and this was recorded in their care plan.

People were provided food and drink they liked and helped with meal preparation where able. Healthy food options were encouraged and body weights were monitored where needed. People said they had enough to eat and drink. People were supported to access the healthcare services that they needed and staff either supported them to attend the surgery or arranged for professionals to visit in the home.

On the whole staff were kind and caring but there was a lack of consistency in the caring approach by staff – we have referred to two specific examples in the body of the report. They had a good rapport with the people they were looking after. People were at ease with the staff and supported them to do daily living activities, be part of the local community and to be as independent as possible. People could raise any complaints or concerns they had during 'house' meetings, with their keyworker and through care plan reviews.

Regular meetings were held with people using both services and with the staff team. Staff meetings and management meetings were scheduled regularly and staff were encouraged to express their views.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 in Fieldview and those that received the community based service said they were safe and the staff were there to help them stay safe. The staff were aware of their responsibilities to safeguard people and to report any concerns. Safe recruitment procedures were followed at all times to ensure only suitable staff were employed.

The risk assessments and management plans in place ensured that where risks had been identified measures were taken to reduce or eliminate the chances of injury. Behavioural management plans had been written to ensure the staff dealt with events in a consistent way.

There were sufficient staff available to support people in both services and to meet their identified care and support needs.

Medicines were managed safely and staff received training. Staff were regularly reassessed to ensure they followed safe practice when administering medicines.

Is the service effective?

Requires improvement

The service was not fully effective.

Although both staff teams had completed a training package in respect of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards they had limited understanding of how this should be applied to their daily work. People's rights may not be properly recognised, respected or promoted.

We found Fieldview to be meeting the requirements of the Deprivation of Liberty Safeguards

People were looked after by staff who had the necessary knowledge and skills and received the appropriate training. The staff were well supported by the registered managers.

People had enough to eat and drink and where appropriate were encouraged to participate in meal and drink preparation. Where people were at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

People were supported to access healthcare services and to maintain good health.

Is the service caring?

Requires improvement

The service was not always caring.

Summary of findings

Overall there was a good rapport between people and the staff looking after them. However the staff did not always ensure that people's basic care needs were met. The community base staff did not respect the fact they were working in people's own home.

People were satisfied with the way they were looked after and were at ease with the staff. People were involved in making decisions about their care and support and their views were actively sought.

Is the service responsive?

Requires improvement

The service was not fully responsive to people's needs.

People in Fieldview and those supported in their own home may not receive the care and support they need because information recorded in their care plan was not accurate.

People were regularly asked for their views about how they wanted to be looked after and about things that affected their daily lives. The staff responded to any comments they made.

Is the service well-led?

Requires improvement

The service was partially well-led.

The procedures in place to monitor the quality and safety of both services were not good enough. Where audits or surveys had been carried out there were no actions plans in place in order to ensure that the required improvements were made. No surveys had been carried out with people using either service or other interested parties.

People and staff said that both registered managers had regular house and staff meetings. People were encouraged to express their views about matters that affected their daily lives.

Fieldview

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 and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by two adult social care inspectors. The inspection took place over two days, one day in the community based service (23 July 2015) and one day in the care home (24 July 2015).

The last inspection of the service was undertaken in July 2014 and at that time we found there were two breaches of legal requirements. They were in respect of the assessment and care planning processes in place and because risks were not identified, managed or regularly reviewed. Following this inspection the provider submitted their action plan and told us what action they were taking to rectify the breaches. We have checked out that the improvements have been implemented and sustained.

Prior to the inspection we contacted health and social care professionals and asked them to provide feedback about both services. We have included their views and opinions in the main body of the report. We also looked at information we had about the service. The information included the statutory notifications. A notification is information about important events which the service is required to send us by law. We had not asked the provider to complete the Provider Information Return (PIR) before this inspection.

During the inspection we were able to speak with five of the seven people who received a community based service and four of the six people who lived in the Fieldview care home. Some of the people we spoke with were able to tell us about the service they received and how the staff looked after them. We spent time with both registered managers, spoke with four community based care staff and four staff members from Fieldview. We looked at the support plans for 10 people and other records relating to the running and management of the community based service and the care home.

Good

Is the service safe?

Our findings

People who lived in Fieldview said, "I am safe here", "The staff make sure I am safe" and "I have to have someone come with me when I go to the shops". During our inspection we noted that one person was being very loud and disruptive however their behaviours were not directed at the other people in Fieldview and the staff attempted several means to pacify them. Those people who received the community based service in their own home made the following comments, "The staff make sure I don't hurt myself" and "Everyone is very friendly and we all get on well".

In the last inspection report we said that environmental risk assessments were not completed for those people who received care and support in their own home. The provider and registered manager had not taken any action and this required improvement. On day two of the inspection the registered manager had sourced an assessment document and gave assurance these would be completed promptly. The document covered the physical environment both outside and inside the person's home. As part of the care planning process a range of other risk assessments were completed for each person. Examples included the risks of malnutrition, the risk of falls and other person-specific assessments around being out in the community or risks posed by hot water and kitchen utensils. One person needed staff to assist them with moving and handling procedures. A mobility and moving and handling plan had been written and this set out the equipment to be used and the numbers of staff required to support the person.

Concerns were raised at the end of 2014 under safeguarding procedures regarding the management of people's money. This investigation had uncovered a number of areas where people had been charged for items incorrectly. The provider had cooperated to some extent in rectifying how people's money was managed and had made some reimbursements. The safeguarding monitoring had ceased. However there was still an on-going investigation by the commissioning team. We saw systems in place to account for people's spending, receipts and records were kept where appropriate.

There was an emergency business contingency plan in place that covered the people in Fieldview and those who were supported within their own homes. The plan detailed what actions would be taken in the event of incidents that affected the running of the home and the personal care service. The plan covered failure of utility services, flood, damage to the building and absence of staff.

People had a personal emergency evacuation plan prepared in the case of a fire and these stated what support the person would need to evacuate Fieldview or their own home. The staff team were provided with the necessary information so that they would know what to do in the event of a fire. They would also be able to share this information with the fire service. The outcome of a recent fire had been handled well by the provider and staff team which meant people in the shared house had to vacate the property.

In Fieldview all the necessary daily, weekly, monthly and three monthly checks had been completed. These included the fire safety checks, the hot and cold water system checks and any maintenance checks.

Staff from both services completed safeguarding training during their induction and on a regular refresher basis. Staff training records confirmed that all staff were up to date with their training and when their next refresher training was due to be completed. Staff from both services said they would report any concerns they had in respect of the people they were looking after to the registered manager or the on-call manager. The registered managers had both been booked to attend the level two safeguarding training with Gloucestershire County Council in July 2015 but this had been cancelled. They were waiting to know when this was being rescheduled.

The safeguarding policy detailed the types of abuse and the signs that abuse may be occurring. The policy did not provide any guidance for staff on how they could report directly to Gloucestershire County Council safeguarding team or the Care Quality Commission. The policy was last reviewed in January 2015 but would benefit from including this information. Both the registered managers talked about the safeguarding reporting protocols they would follow if concerns were raised, alleged or witnessed and were fully aware of the procedures.

Safe recruitment procedures had been followed for all staff. Appropriate pre-employment checks written references and a Disclosure and Barring Service (DBS) check were in place. The registered manager for the community based

Good

Is the service safe?

service said one person who lived in the shared house was involved in the interview process for new staff. These measures ensured people were looked after by suitable staff.

Staffing numbers in Fieldview were based upon the support needs of the people who lived there and the activities they each had arranged on a given day. The registered manager was available each weekday but also worked shifts when required. On the day of inspection the registered manager and two staff were on duty (plus a supernumerary member of staff). Overnight there was a staff member that could be called upon to deal with any events. Staff felt that the staffing levels were appropriate and staff were available when people had outings arranged. People were looked after by staff they were familiar with however there were planned staff changes. Two of the team were to be moving to another care service run by the same provider.

Since the last inspection the six people who were supported by the community based service in the shared house have been reassessed by the local authority. This was because their care and support needs had changed. This had been done in order to set up the individual community based support they needed and not 24 hour residential care. The registered manager had already been informed of the provisional funding arrangements for each person (made up of individual 1:1 hours and shared hours) and the number of staff on duty met these arrangements.

People were protected against the risks associated with medicines. For those people who were supported by community based staff, the level of support they needed was determined and recorded in their care and support plan. Each person who lived in Fieldview was supported by staff with their medicines. Staff completed safe medicine administration training before they were permitted to support people. Regular competency assessments were carried out with all staff to ensure medicines were administered safely. Staff we spoke with confirmed training and competency assessments had been carried out. Staff were provided with information about the medicines people were prescribed and completed a medicine administration record (MAR chart) after medicines had been given.

Requires improvement

Is the service effective?

Our findings

People we spoke with made the following comments: "The staff help me and encourage me to do things", "The staff help me with everything" and "I get asked what I would like to eat and what I would like to do. I get on well with everybody but I prefer to spend time on my own". People who were provided with the community based services were supported to maintain their tenancy. They were also supported to be ready for transport to community activities and to complete their daily living activities.

The registered manager for Fieldview had completed Mental Capacity Act 2005 (MCA) training for practitioners and had a good understanding of capacity issues. The MCA is a law about making decisions and what to do when a person cannot make decisions for themselves. All staff from both teams completed an on-line MCA and Deprivation of Liberty Safeguards (DoLS) training package and this included a post training knowledge check piece of work. DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty. These safeguards protect the rights of the people who live in the care home to ensure that the restrictions placed upon their freedom and liberty were appropriately authorised and were in the person's best interests. The registered manager said that two people in Fieldview were subject to DoLS restrictions.

Staff we spoke with in both services were clear about asking people for consent but less clear about capacity issues and best interest decisions process.

The mental capacity assessments completed by staff in both services, as part of the care planning process were on the whole not completed properly. The plan for one person stated they had limited mental capacity, could make decisions "in the here and now on daily living issues" but had limited ability to make informed decisions. The staff had written that the degree of risk was high but in the section where the assistance required was recorded there was no guidance for staff to support the person with making decisions. For another person their plan stated they had restricted mental capacity and again the assistance required section was left blank. There was no indication how this restricted mental capacity affected the person's daily life. In other parts of the person's care documentation (management of personal finances) staff had recorded that the person had refused to sign the care plan. This person's finances were managed by the court of protection therefore this record of refusal was not correct - the person was unable to sign their agreement.

One person was supported by an Independent Mental Capacity Advocate (IMCA). Decisions were recorded in this person's care plan regarding health matters that according to a social care professional had not yet been made in a best interest meeting with relevant parties. This again evidences that staff have a limited understanding of the Mental Capacity Act 2005 and the associated code of practice.

This was in breach of regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

Staff from both services told us they gained people's consent before starting to provide support. One member of staff said "If I am planning to do something with someone I always ask them if they are happy to proceed". They also said that one person often did not want to be supported with personal care tasks, they then offered help later or another member of staff tried. Another member of staff said they judged the person's behaviours and demeanour to see if they were happy to be supported.

Staff from both Fieldview and the community based service said they were well supported. They said "I feel we are listened to", "The manager takes on board our suggestions" and "Any issues are fed back up to the senior management team". They told us they received regular supervision and there were regular team meetings. Records of all staff meetings were kept and shared with those staff who had not attended. The registered manager for the community based staff completed all staff supervisions. In Fieldview the registered manager and team leaders shared the responsibility for staff supervisions. Records showed when supervisions were due and when they had been completed.

Staff received the training they needed to do their job. New staff to both services completed an induction training programme. This has recently been revised in order to comply with the Care Certificate. The Care Certificate became law on 1 April 2015 and sets out 15 fundamental

Is the service effective?

standards that new health and social care staff have to complete. We saw evidence in staff files of completed induction programmes and one new member of staff in Fieldview confirmed they had a training programme to complete. Induction training consisted of food hygiene, infection control, safeguarding adults, administration of medicines, moving and handling and first aid training. Staff who worked in the care home also completed positive behavioural management training and Mental Health Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Computer records showed only a small number of refresher training sessions were overdue but this was in hand.

People in Fieldview were asked to make choices about the main meal of the day. Each person was encouraged to have a say about one meal choice a week and to assist in the preparation and cooking of the meal. The staff supported people to eat healthily. One person said that if they did not like the meal that had been cooked they were able to have something else. Concerns had been raised prior to our inspection by health and social care professionals that there was insufficient food in the home. Each person we spoke with said they had enough to eat and there was always food and drink available. The cupboards and the fridge were well stocked.

When we visited last year one person was at risk of weight loss because of poor dietary intake. A plan was in place to monitor this person's body weight and a strategy was being followed if the person's weight fell below a certain level. Staff told us the person's weight had now stabilised and they were eating better. They explained they did not regularly measure the person's body weight because if the person knew they had put on weight they would then stop eating. Staff said they made a visual assessment of the person's body regularly and would contact the relevant healthcare professionals if they were concerned.

The people who were supported in the shared house were encouraged to have a healthy diet and their body weights were monitored. The people in the shared house had lived together for many years and chose to have their meals together. They had a say about what they would like to eat as they told the staff in the house meetings. The community based support staff did the household shop and on the whole prepared and cooked the meals. Some people said they liked to help with preparing vegetables or washing up dishes after a meal.

People were supported to maintain good health and were registered with the local GP surgery. Staff supported them to attend the surgery and make appointments with other health and social care appointments whenever needed. Both Fieldview and the community based service worked alongside the community learning disability teams and mental health services to ensure people received the support they needed.

Requires improvement

Is the service caring?

Our findings

People who were supported in their own homes said, “The staff are good to me”, “They help me” and “When I get upset they comfort me and help me calm down”. People in Fieldview said, “I am quite happy here. I get on well with the others but tend to keep myself to myself” and “I like the staff and I like my keyworker”.

There was a good rapport between the staff and the people being looked after however one person who lived in the shared house had recently suffered damage to their personal belongings. The staff had actively supported the person to replace essential items but had been unable to encourage them to buy new bedding

Observations we made during our inspection was that one person who lived in Fieldview had entered the ‘shared home’ of the people supported by the community based service. It was evident it was accepted practice that the staff and other people were able to enter the house and come and go as they pleased. There was little respect for the fact that the house was the six people’s own home and the staff used the home as ‘their office’. The person we saw who entered the home uninvited had taken food from their fridge and proceeded to eat this. This was discussed with both registered managers.

Staff from the community based team and Fieldview were knowledgeable about the people they were looking after. They knew how each person liked to be supported and the particular care needs they had. They ensured that people’s dignity and privacy was respected and ensured that personal care needs were met on a daily basis. The people who lived in the shared house had lived together for many years and their social lives and the activities they liked to do were inter-linked with each other.

People in Fieldview and those who lived in their own home contributed as much as possible in making decisions about how they were looked after and supported. Keyworker reviews were completed on a monthly basis. A keyworker is a member of the team who has been allocated to a person: their function is to take a social interest in that person, develop opportunities and activities for them, and in conjunction with the rest of the staff lead on developing the person’s support plan. People were involved in the process, were able to say who they wanted their keyworker to be and were encouraged to make their views known. Records we looked at evidenced that the person was able to talk about any changes they wanted to the way they were looked after or supported. One member of staff said that this process had enabled them to get to know the person “very well”. Input was sought from relatives and health and social care professionals where necessary.

People from both services were encouraged to be part of the local community. Some people were able to go out independently whilst others needed to be supported by staff. New staff were not allocated to escort people away from Fieldview until they were competent enough to do so and knew the person well.

Requires improvement

Is the service responsive?

Our findings

On the whole the care planning system was satisfactory however there were specific areas where improvements were required to ensure that accurate information was recorded. The advanced care plans we saw contained a statement that said, "a DNAR (do not attempt resuscitation) form has been completed by X's GP". This statement was in several of the care files we looked at and we discussed this with both registered managers. Initially we were told that the GP's had not returned the forms but then we were told that the information was in fact incorrect. This discrepancy has the potential to mean that people may not receive the care and treatment they needed. One advanced care plan said the person had completed a statement of their wishes and care preferences but staff did not know where this was recorded. The plans also said, "X's loved ones and/or anyone with any form of lasting power of attorney to be fully involved and informed". This statement had been generated by the planning system but both staff teams had not considered there could be implications by this being recorded in the care plans.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Since the last inspection the six people who were supported by the community based service in the shared house had been reassessed by the local authority. This was undertaken in order to determine each person's individual care and support needs and to identify how much community based support they were to be funded for. At the time of our inspection the service provided to people was based upon provisional agreements made in respect of the level of support each person needed. The registered manager was aware of the new funding arrangements for each person but the individual assessments, care plans and weekly timetables of support were received on day one of the inspection. These arrangements were to be fully implemented on 1 August 2015 along with the electronic call monitoring system. People were provided with a mix of individual 1:1 hours for specifically identified support tasks and shared hours for daily living activities.

The registered manager was mistakenly under the impression that the 1:1 hours did not have to be delivered as per the weekly timetable. Some of the 1:1 hours were allocated to support people with daily personal care tasks, whereas others were to support them with tasks that did not have to be so time specific (for example shopping, household tasks). The registered manager was also unclear as to the responsibilities of the service to monitor compliance with the support plans and the electronic call monitoring system (ECMS). Following the inspection we spoke with the provider and they stated there would be an identified member of staff who would monitor the ECMS.

A new care planning system had been introduced since the last inspection for both services. Records were made electronically with paper records being stored in the person's care file. People were involved in the preparation of their care plans and had signed their plans. On their behaviour plan one person had written "not entirely true facts" and on their cooking plan "I will endeavour to fulfil this obligation". The person had signed their agreement to the plan. The reviews of both these plans showed that behaviours had reduced as a result of the first plan but the person had continued to decline to engage with food preparation.

The care plans covered the full range of daily living needs, communication, health and medication, nutrition, social interaction and behaviour support. The care plans addressed both their mental and physical health needs. Where people were subject to a community treatment order (CTO) the conditions of the CTO were detailed in the care plan. A CTO means the person will have supervised treatment after a hospital admission and will need to comply with the conditions of the order. Staff were aware of the conditions of those orders.

In May 2015 the registered manager had written reactive and management strategy for those people in Fieldview. The aim of these was to reduce and discourage identified behaviours using a consistent approach. The plans listed initial interventions and stated what actions to take if the situation continued to deteriorate. It was evident that all staff had read and signed these plans.

Keyworker reviews were completed on a monthly basis for people in Fieldview and those who received support in their own home. The reports recorded what had gone well during the month, any events and health issues, how the care plans were going and any changes that were needed. The reviews were carried out by the person's key worker and involved the person. These measures ensured that people received the care and support they needed and the staff were able to respond to changing needs.

Requires improvement

Is the service responsive?

People in Fieldview and those in the shared house had a say about the day to day running of their homes. Meetings were held on a monthly basis and people were encouraged to have a say about meal choices, social activities and the household chores they liked to do.

People were made aware of the complaints procedure and this was discussed each month in the review meetings.

Copies of the complaints procedure were displayed in each of their bedrooms in Fieldview and communal areas. The procedure set out the process of dealing with any complaints received. People we met during our inspection said that the staff listened to them and they did not raise any complaints with us.

Requires improvement

Is the service well-led?

Our findings

People in Fieldview and those supported in their own home did not provide us with any feedback as to how they felt about the way the service was run. The registered managers had regular 'house meetings' and encouraged people to make comments and to say how they felt.

The registered manager for the community based service shared a recent audit that had been completed by the pharmacist who supplied people's medicines. The pharmacist had stated that the type of care setting was domiciliary care however the report was care home focused. The registered manager had not completed an audit to ensure that staff were administering medicines to people safely. No audits were undertaken to ensure the medicines administration sheets were completed correctly. At the beginning of the year there had been a mix up with the medicines for one person and this had been referred by the community support staff to the safeguarding team. Whilst this event had been as a result of communication issues between healthcare professionals there had been no review of what went wrong in order to identify lessons to be learnt.

Another audit the registered manager of the community based service spoke of was the health and safety audit of the shared house. This however was not an audit that we would expect to be completed for people supported in their own homes. Individual environmental risk assessments must be completed for each person - the registered manager had already located an appropriate form.

The registered manager said that in March 2015 an audit had been completed in respect of the key question 'Is this service safe?' and then recently a second audit to check whether 'Is the service effective?'. Neither of these pieces of work had resulted in any feedback or action plan. An action plan would be useful in order to drive forward any improvements that were identified.

A staff survey had been completed with the community based staff in November 2014 and four of six forms were returned but only four forms had been returned. The quality assurance manager had produced a summary of the findings. There were a number of issues raised by the staff and referred to in the summary but there was no action plan. The survey was due to be repeated in September 2015.

The absence of action and improvement plans was discussed with the registered manager (community based service) and the quality assurance manager at the end of day one of the inspection.

No surveys had been completed with people using the service (Fieldview or community based service), with their families or friends, or with health and social care professionals involved with the service. A good opportunity to gather feedback about how the service was doing and how people's needs are met was being missed.

At the end of 2014 concerns had been raised by commissioners from Gloucestershire County Council. These concerns were in respect of the management and accounting processes of people's personal money. Some remedial actions had already taken place however the full investigation was still on-going. Again there was no action plan in place to drive forward the improvements that were needed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 .

Both registered managers had regular manager's meetings with the provider and the quality assurance manager. They had to complete a manager's report for the provider, reporting on staffing issues, audits that had been completed, any accidents and incidents that had occurred, complaints received, reviews completed and notifications sent in to CQC.

Staff meetings were held on a monthly basis for the staff team at Fieldview and every two weeks for the community based staff. Staff said they were asked how things were going and were encouraged to make suggestions about meeting people's needs and "doing things differently". They said they were listened to. Staff said the registered managers often covered shifts, were visible and approachable. Staff said they would have no hesitation in raising any concerns they had.

The care plans for those people in Fieldview were reviewed on a monthly basis (including the key worker review) and in greater detail on a six monthly basis. Any changes to the

Requires improvement

Is the service well-led?

care and support needs were identified and the plans amended. Keyworker reports were also completed on a monthly basis by the community based staff and given to the registered manager. From these reviews the registered manager said they identified any action points and instructed the staff what needed to happen.

All policies and procedures were kept under continual review. The registered managers said that each time they had a managers meeting with the provider one of two policies were discussed in order to check they were still appropriate. The registered manager said they would ensure at the next meeting the additions to the safeguarding policy (contact details for other agencies) was addressed. As new policies were issued staff had to sign to say they read and understood the policy.

Both registered managers were aware of when notifications had to be sent in to CQC. A notification is information about important events which the service is required to send us by law. These notifications would tell us about any events that had happened in the home or had happened whilst people were being supported by the community staff. In the last 12 months four notifications had been sent in. The service provided all information about each of the events and worked with other agencies to resolve the issues.

The home's complaints procedure was displayed in communal areas in Fieldview. People who were supported in their own homes were provided with a copy of the complaints procedure in their care file. We were told that neither service had received any complaints in the last 12 months. After the inspection the provider told us this was incorrect and there had been two complaints but these records were not shared with us. However as we have already stated there have been occasions where things that have gone wrong have not resulted in any analysis to prevent a reoccurrence of the event. This would enable the registered managers to review their practice and to drive improvements forward.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered persons must ensure that where a person who lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and the associated code of practice. The staff must be able to apply those principles for any of the people they are caring for. Regulation 11 (1) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered persons must ensure that an accurate, complete and contemporaneous record of care and treatment provided is kept. This is to ensure people are protected against the risks of receiving unsafe care. Regulation 17 (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered persons must ensure there is an effectively operated system in place to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (1), (2) (a) and (2) (b).