Midland Care Homes Ltd

The Field View Residential Home

Inspection report

The Slough
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Redditch
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Tel: 01527550248

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18 March 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: The Field View Residential Home provides accommodation and personal care for up to 20 people. It provides care to older and younger people living with dementia, people with mental health issues and people with sensory impairments. During out visit 19 people lived at the home.

People's experience of using this service:
• Risk's associated with people's planned care and within the building were not always identified or managed safely.
• Staff were not always recruited safely.
• Medicines were not always safely managed.
• Referrals to other healthcare professionals were not always made in a timely way.
• Advice from healthcare professionals was not always followed.
• Systems and processes were not effective. Where areas of concern had been identified, action had not always been taken to make improvements.
• Most people felt safe and spoke positively about their care. People told us staff were caring and kind.
• People's individual needs were assessed to ensure they could be met by the service.
• People made decisions about their care and were supported by staff who understood the principles of the Mental Capacity Act 2005.
• People's told us their privacy and dignity was respected.
• People's nutritional needs were met.
• People's care plans lacked detail. Further information was required to help staff provide personalised care.

• Systems were in place to manage and respond to any complaints or concerns raised.
• The registered manager and the director were open and transparent and took some immediate actions to resolve concerns found at our visit.

This is the second consecutive time the home has been rated as Requires Improvement.

The registered provider was in breach of Regulations 12 and 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Rating at last inspection: At the last inspection the service was rated as requires improvement. (The last report was published on 5 April 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection. The service continues to be rated as 'Requires Improvement' overall.

Enforcement: Action we told provider to take (refer to end of full report)

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below

The Field View Residential Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two inspectors and an interim inspection manager carried out this inspection.

Service and service type: The Field View Residential Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: Our inspection was unannounced and took place on 18 March 2019.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as serious injuries. We liaised with commissioners of the service including local authorities, and Healthwatch. Healthwatch is an independent organisation which collects people's views about health and social care services. The feedback from these organisations was used in planning for the inspection and helped identify some key lines of enquiry.

During our inspection visit we spoke with:
- Four people who were being supported by the service
- One relative of a person using the service
- Three care staff
- The cook

• The provider's director
• The registered manager

We looked at:
• Four people's care records
• Three people's medicine records
• Two staff personnel files, recruitment, induction and training records
• Meeting minutes
• Records of complaints and compliments
• Management quality audits and checks

We completed checks of the premises and observed how staff cared for and supported people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We used the SOFI to observe how staff interacted and cared for people with dementia on one occasion in the main lounge.

After the inspection visit we received information which provided assurance the issues we had identified had either been addressed or action was planned to make the required improvements to benefit people.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations were not met.

Assessing risk, safety monitoring and management
• Assessment tools to determine risks to people's health and well-being, such as skin damage, falls or malnutrition were used. However, many we reviewed were incomplete.
• Completed assessments were not always accurate. For example, one person had been assessed as 'no risk' for eating and drinking but information within their care plan contradicted this and indicated they were 'at risk'.
• Care plans lacked important information and guidance staff needed to help them to manage and mitigate risk. For example, one person had been assessed as 'very high risk' of skin damage. Their care plan instructed staff to 'keep maintaining good personal care'. There was no further advice for staff to follow such as, encouraging the person to stand or reposition themselves regularly to relieve pressure on vulnerable areas of their body.
• Equipment was not always monitored to ensure it was safe to use. It is important pressure relieving mattresses are set at the correct setting for a person's weight to ensure they provide effective pressure relief. One person's mattress was set incorrectly and was not working effectively. This person described their mattress as, "Not good at all, that is why I don't sleep on it." The registered manager told us they had discussed this with the district nurse and following our visit confirmed a new mattress had been delivered.
• Some people did not have accessible or working call bells in their bedrooms. One person told us, "I was really frightened to go to bed as I knew I wouldn't be able to get help." We discussed this with the registered manager who told us call bell sockets did not allow a call bell and sensor mat to be connected at the same time. The director told us immediate action would be taken to order new electrical sockets to enable people to use their call bells to seek assistance when needed.
• Environmental risks were not always identified. For example, some fire doors were propped open with a wedge and in the downstairs toilet the call bell fitting had fallen off the ceiling leaving electrical wires exposed. Cleaning products, including bleach, were not stored securely. This posed a risk as people living at the home were mobile and living with dementia. The registered manager took immediate action to remove the items.

Using medicines safely
• Medicines were not always managed or stored safely. For example, medicines were not always stored at the correct temperatures.
• Staff did not always follow good practice when they administered people's medicines. One person's medicine was given covertly (disguised in their drinks) and a drink had been left in the person's bedroom without staff supervision. It had granules at the bottom of the beaker and residue floating on the top. Staff confirmed this was the person's medication which had been signed for as 'taken' in their records. This meant we could not be assured that people were taking their medicines as prescribed.

• This practice posed further risks as other people living with dementia could have entered the person's bedroom and picked the drink up for themselves.
• When people's medicines are administered covertly, it is important this is regularly reviewed with the person's GP. This had not happened since 2016. Also, advice had not been sought to confirm crushing the medicines and giving in drinks was a safe way of administration. Following our visit, we were assured that this person's medication was being reviewed by their GP.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Staffing and recruitment
• The provider's recruitment process did not ensure staff were suitable for their roles in line with the requirements for employers in health and social care. For example, the provider had only completed basic Disclosure and Barring Service checks rather than enhanced checks. The DBS is a national agency that keeps records of criminal convictions. There was also no evidence one staff member's reference had been checked for authenticity.
• Following our visit, the director assured us risk assessments had been put into place for those staff members and enhanced DBS checks had been applied for. They advised us all other staff members employed had enhanced DBS clearance in place.
• There were enough staff to meet people's needs. Staff had enough time to spend with people to meet their physical and emotional needs. One staff member described staffing levels as 'good'.

Systems and processes to safeguard people from the risk of abuse
• People felt safe. One person told us, "I think the staff here do make me feel safe." A relative told us, "I know [person] feels safe."
• Staff had received safeguarding training and understood their responsibility to escalate concerns to their managers to keep people safe from abuse and avoidable harm. One staff member told us, "I would go and get (Registered manager) straightaway or the senior on shift."
• However, the provider's procedures had not always been followed when safeguarding incidents had occurred. For example, an incident form had not been completed when an altercation had occurred between two people and a safeguarding referral had not been made to the local authority as required. The registered manager told us they would address this with the staff member concerned. The director later confirmed a safeguarding referral had been made to the local authority.

Learning lessons when things go wrong
• The registered manager kept a log of accidents and incidents and action had been taken when things went wrong. For example, one person was injured when a wardrobe fell on them. Following this incident, all wardrobes had been securely fixed to walls to reduce the risk of reoccurrence.
• However, accidents and incidents did not always prompt a review of people's needs in a timely way.

Preventing and controlling infection
• Staff prevented the spread of infection by wearing personal protective clothing when necessary.
• The home was generally tidy, but some areas, including people's bedrooms, needed to be cleaned. For example, there was dust and debris on windowsills and a wheelchair smelt of urine.
• The laundry room did not support good infection control practice. For example, there was no clear separation of clean and dirty linen.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they moved to the home. Assessments included people's care and support needs, personal preferences and life style choices.
• People were offered a 'trial period' to decide if the home was the right place for them to live and the provider could ensure they could meet the person's needs as they settled into the home.

Staff support: induction, training, skills and experience
• Overall, people were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. The director told us they only employed staff who had experience of working in health and social care.
• Staff completed an induction and worked alongside an experienced member of staff before working on their own to ensure they knew how to support people.
• Staff completed the training they needed to be competent in their role. One staff member said, "We had manual handling training last week and it was good. It was probably the longest manual handling training I have had, it was very detailed."
• Staff received regular supervision meetings with their manager to discuss any concerns or training and development needs. Staff felt well supported by the management team and by each other. One staff member said, "If I'm not sure about anything, [registered manager] has always got the answer."

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink in line with their preferences. One person said, "The food is okay, I have no cause to complain. If I have asked for something different with food, they will bring it." Another person told us, "I like the food."
• People were offered daily food and drink choices. The cook was in the process of reviewing the menus and introducing some changes to add more variety as food menus had not been changed in the past year.
• People who were at risk of losing weight, had their food and fluid intake monitored. A dietician had recommended one person had their meals fortified with extra calories. However, the cook and the registered manager were not aware of this recommendation and therefore action had not been taken to support the person. Despite this, the person's weight had remained stable.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People had access to the healthcare they required and were supported to access healthcare services, such as their GP and a chiropodist.

• However, this was not always done in a timely way. For example, one person had fallen fourteen times between October 2018 and March 2019 and they had not been referred to the GP or falls prevention team until their fourteenth fall.

Adapting service, design, decoration to meet people's needs
• The home had two levels with bedrooms on the ground and first floor. People with limited mobility lived on the ground floor.
• The provider was working on a refurbishment programme to improve the environment. For example, dining chairs had been reupholstered and the windows at the front of the building had been replaced in response to feedback from staff and relatives.
• Further improvements were required to make the environment more suitable for people who lived with dementia.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staff understood the principles of the Act and asked people for their permission before supporting them. One staff member told us, "Just because they are elderly, and some have dementia doesn't mean they can't make their own choices and decisions. Having dementia doesn't make you incapable."
• However, we could not be sure the registered manager and provider understood their responsibilities under the Act. This was because previously and during this inspection mental capacity assessments were not sufficiently detailed to evidence how decisions about a person's capacity had been made.
• One person had some restrictions placed on their daily choices that could amount to a deprivation of liberty. The person's capacity to agree to these restrictions had not been assessed and there was no evidence available to ensure the restrictions were in the person's best interests.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations had been met.

Respecting and promoting people's privacy, dignity and independence
• People told us staff respected their privacy. One person told us, "You are given privacy."
• A privacy screen had been purchased to offer people privacy in the communal areas. A staff member explained that it was important if the GP visited but the person did not want to go to their bedroom.
• However, during our visit we observed people's right to privacy was not always respected. For example, when we asked the registered manager and staff if there was a private area we could use to talk to staff, we were offered people's bedrooms. This meant that people would not have been able to use their bedroom during our visit.
• Staff treated people with dignity. A relative said, "[Person] always seems clean and tidy."
• However, the lack of attention to people's surroundings was not demonstrative of respecting people's dignity. For example, some bedding was worn, stained and ripped. One person's bedroom curtains were hanging off the curtain pole and there was no shade on the central light fitting. Staff had not identified these as issues for the management team to address.
• Following our inspection, the director assured us new bed linen, duvet sets, and lamp shades had been ordered and the curtains had been repaired.
• Staff understood the value of increasing people's independence. For example, one person stood up and started to walk out of the lounge. This person was a little unsteady so a staff member enquired, "Do you want me to walk with you?" The staff member then walked beside this person so they could monitor their wellbeing. One staff member told us, "If they (people) want to be independent and they have capacity to do so, 100% they should be able to do it. They shouldn't have anything less than I have in my house when I go home."

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were treated well. Comments included, "There are good people working here" and, "The staff are very kind, very helpful."
• In a recent survey a relative had commented, 'Staff have been outstanding in caring for my parents.'
• We observed staff were kind, caring and supported people in a patient and friendly manner. For example, one person was unsteady on their feet and a staff member immediately provided support. They placed a reassuring hand on the person's back and offered praise and encouragement by saying, "You are doing really well." The person smiled.
• Staff knew people well. The director spent time with people on an individual basis and knew people by name. They told us, "If my parent was in a care home I think to myself, how would I want them to be treated. I have to treat people here the same."
• Staff told us changes made to the management structure had impacted positively on people's care. One

staff member said, "[Director] will always ask if there is anything we need. If it is for the residents, we can have it. It is no problem. It wasn't like that with the old management."
• People were encouraged to celebrate special occasions. The day before our inspection people had celebrated St Patricks Day and resident meeting minutes detailed 'Mothering Sunday will soon be upon us and we will have flowers throughout the home for all of the mums'.
• People's equality and diversity rights were respected. The statement of purpose described how people were treated as 'unique individuals' with their differing cultural, religious and sexual orientation needs.

Supporting people to express their views and be involved in making decisions about their care
• People were encouraged to make decisions about their day-to-day care. Staff encouraged people to make decisions about what they wanted to eat, drink and how they wanted to spend their time.
• Staff understood the importance of communicating with people, so they were involved in making decisions about their care. One staff member explained some people could sometimes become anxious and said, "It is mainly down to frustration if they can't understand us. You have to always keep talking and explain what you are doing. If they are not happy with me helping them in that moment, that is fine."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff knew people well and used their knowledge of a person to engage in meaningful conversation.
• Staff were responsive to people's individual needs. One member of staff noticed a person was fiddling with their clothing. They immediately went over to offer help. They established the person was looking for a handkerchief which was then promptly provided.
• Each person had a care plan which contained some information about their preferences. However, the information was limited and did not support staff to deliver personalised care.
• Some care plans did not contain accurate information and had not been updated when people's needs had changed. For example, one person's care plan informed us they used a walking stick. Despite the care plan being recently reviewed, the registered manager told us the person had not used the walking stick for some time.
• A member of care staff was designated to take the lead on social activities each day. During our visit we observed some people made Easter decorations whilst others enjoyed being part of the group and chatting together.
• It was not always clear what activities were available to people who chose or needed to stay in their rooms because of ill-health. However, staff assured us they regularly checked people to ensure they did not become socially isolated.
• Staff felt that people's independence could be increased further by being more involved in the running of the home. For example, one person used to fold the table cloths but this was no longer encouraged.
• Providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS). The standard aims to make sure that people are given information in a way they can understand. We found information was not always presented in a way people could understand. For example, one person did not speak English. We saw no evidence their care had been communicated to them in a way they would understand.

Improving care quality in response to complaints or concerns
• The complaints procedure was available in the service user guide which was given to people when they moved in. However, this was not always in a format people could understand.
• People told us they had 'no cause to complain' about the service and felt comfortable to make a complaint directly to the manager or provider.
• The registered manager told us they did not record 'niggles' as they were resolved straight away. One formal complaint had been received within the past twelve months which had been investigated and resolved.

End of life care and support
• The home provided care to people at the end of their life if they wished to remain at Field View.

• The registered manager told us staff worked with other healthcare professionals, so people had all the anticipatory medicines in place to remain comfortable and pain free.
• However, people's end of life wishes were not recorded. The registered manager told us this was something they would implement in the future.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• At our last inspection we rated well-led as 'Requires Improvement' because systems and processes to keep people safe were not always effective. At this inspection similar concerns were identified.
• Quality assurance systems were not always effective. We found risk had not always been identified or managed. Where risks had been identified, action had not always been taken to mitigate these risks. For example, some people were at risk of skin damage and used pressure relieving equipment. However, checks to ensure the equipment was safe to use did not take place.
• Risks in the environment had not always been identified or managed. For example, the gas safety certificate had expired. Where risks had been identified, action had not always been taken to mitigate risk. For example, water temperatures and medication room temperatures were recorded above the recommended temperature and no action had been taken to investigate this.
• We found the provider's recruitment processes had not identified some staff had started working at the service without the recommended safety checks .

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

• Registered providers and registered managers have a legal responsibility to inform us (CQC) about any significant events that occur in the home including any serious injuries or safeguarding events.
• At our last inspection the provider and previous manager had failed to inform us of a safeguarding incident. At this inspection significant events again, had not been reported to us in a timely way as required. For example, one person had sustained a reportable injury.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents

• Following our visit, the director provided assurance some action had been taken to mitigate immediate potential risk. For example, a new pressure relieving mattress had been delivered and appropriate safety checks had been put in place, and where necessary, referrals had been made to the falls prevention team.
• Some action had also been taken to ensure the safety of the environment. For example, the fire door

wedges were removed and a gas safety inspection had taken place.
• We were provided assurance the provider's quality assurance systems would be reviewed to ensure they were effective in identifying the risks we identified during our visit.
• Despite these issues, staff felt very supported by the registered manager and the director. Comments included, "(Registered manager) is a brilliant manager "and "(Director) has done so many good things for the home. It is nice to have an owner who wants to spend the money to make it better."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Surveys were used to gather people's and relative's views on the service. Analysis from the last survey recorded a high satisfaction rate. A relative had commented, 'The staff and management are outstanding and so supportive to our relative and to us as a family.'
• Resident and relative's meetings were held to gain regular feedback of the service provided. One person had raised a concern about the poor signal on their television and action had been taken to resolve this.
• Staff had regular opportunities to discuss the service and any issues. One staff member told us, "(Registered manager) is very supportive. I never think oh, no I can't ask him that."

Working in partnership with others
• The director was keen to learn from experts within health and social care and had visited other care homes to improve the quality of care at the service. The director told us that following our last visit they had visited other homes to enhance their knowledge of personalised care plans.
• External professionals were also welcomed into the home to identify where improvements were required. For example, the week before our visit a pharmacist had visited to review medication practices. The registered manager told us they had suggested that the medication trolley was secured to the wall and an anchor had since been ordered.
• However, communication within the service needed to be improved because advice from a healthcare professional had not been effectively communicated to staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks Failing to ensure the premises and equipment are safe for their intended purpose

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure systems and processes provide service users with safe care and treatment