Midland Care Homes Ltd

The Field View Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 March 2018 and was unannounced.

The Field View Residential Home is a home which provides care to older people including some people who are living with dementia. The home is two storeys with bedrooms on the ground and first floor. There is lift access to the first floor. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Field View Residential Home is registered to provide care for up to 20 people. At the time of our inspection there were 16 people living at the home.

The provider had taken over the home as a 'going concern' in July 2017. This was their first ratings inspection since taking ownership of the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had recently left the home. The provider had appointed a new manager who had been in post for eight weeks at the time of our inspection visit. The new manager had submitted their application for registration.

People felt safe living at The Field View Residential Home because there were enough suitably qualified and experienced staff to keep them safe. The provider had a programme of training to ensure staff refreshed their knowledge and kept their skills up to date.

Care plans included risk assessments related to people's individual needs and abilities. However, there were no risk management plans to advise staff how to support people who could demonstrate behaviours if they became anxious or frustrated because of their medical condition. Some environmental risks had not been identified. Improvements were needed to ensure the checks and audits that kept people safe and protected were always implemented effectively.

People's needs were assessed before they moved to the home and they were supported to obtain advice from their GP or healthcare professional when their health needs changed. People received their medicines as prescribed to manage their medical conditions, but guidelines to support good medicines management were not always in place.

The provider was keen to promote a caring environment and led by example. People told us the staff were kind, caring and approachable and took time to understand them as individuals. Care staff recognised and respected people's diverse needs and promoted their independence.

Staff worked within the principles of the Mental Capacity Act 2005. They explained how they used their knowledge of the legislation to support people in line with their choices or known preferences. Staff used different methods of communication to ensure people consented to the care they received. Where restrictions on people's liberty had been identified, the appropriate applications had been submitted to the authorising authority.

Each person had a care plan which contained the basic information staff needed to meet people's needs safely. However, some care plans needed additional information to help staff respond to people's emotional and communication needs and provide consistent care and support. Care plans included information about people's dietary needs and staff supported people to eat and drink enough to maintain their health.

The provider understood the importance of ensuring people had stimulation and engagement to maintain the social aspect of their lives. Improvements were being made to the activities provided, but when staff were busy they had limited opportunities to keep people occupied and interested.

The home was clean and staff understood their roles and responsibilities in relation to infection control and hygiene. The provider had procedures to manage risks in the event of an emergency.

The provider and new manager were working together to raise standards, keep people safe and encourage staff. Staff spoke highly of the commitment and motivation of the provider. They told us the provider visited the home regularly and took time to understand the service, the people who lived in the home and the staff who worked there. The new manager was described as 'hands on' and had introduced new processes to make the home safer.

People and relatives were encouraged to engage in the community of the home and to provide feedback and share their experiences so outcomes for people were improved.

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 consistently safe.

Staff understood their responsibilities to protect people from the risk of abuse. The provider checked staff's suitability for their role before they started working at the home and there were enough staff to support people safely. Risks to people's physical health were managed, but there were no plans to guide staff in managing the risks associated with people's emotional or mental health. Medicines were mostly managed safely, but staff needed more guidance about medicines that were not given routinely.

Is the service effective?

Good

The service was effective.

People were cared for and supported by staff who had the skills and training to meet their needs. Staff worked within the principles of the Mental Capacity Act 2005. They give people choices and respected the decisions they made. People were supported to eat and drink enough to maintain their health and were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring.

Staff were kind and approachable and took time to know people and understand them as individuals. Staff respected people's privacy and supported them to make decisions about how they spent their time. Relatives could visit at any time and staff understood their importance in people's lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain the information staff needed to effectively respond to people's communication and emotional needs. People were supported to engage in some occupation

and activities, but there was little to stimulate them when staff were busy with other tasks. People felt comfortable to raise any concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service had not always been consistently well-led.

The new provider and manager were committed to promoting a culture where staff felt listened to and able to share their ideas and concerns. The provider was working closely with the new manager to raise standards, keep people safe and motivate staff. People and relatives were encouraged to provide feedback and to share their experiences of the service. However, improvements were required to ensure the system of checks and audits that kept people safe were always implemented effectively.

The Field View Residential Home

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.

The inspection visit took place on 6 March 2018. The inspection visit was fully comprehensive and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by notification of a safeguarding incident involving an incident between two people who lived in the home. The information shared with CQC about the incident indicated potential concerns about the implementation of the Mental Capacity Act 2005 within the home. We found the provider had taken learning from the incident to ensure staff understood their responsibilities under the legislation.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent a significant period of time observing the communal areas. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During our inspection visit we spoke with six people and four relatives about what it was like to live at the home. We spoke with staff on duty including three care staff and the cook. We spoke with the manager and the provider about the management of the home. We also spoke with a visiting healthcare professional.

We reviewed a range of records; these included four care plans. We looked at daily records, food and fluid charts and six medicine administration records. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at The Field View Residential Home, and relatives told us their relations were safe because staff had a good understanding of the risks related to people's mobility. One relative told us their relation liked to walk around and said before moving to the home their relation had fallen several times, resulting in serious injuries. They described their family member as "very safe" because, "It's definitely knowing that if they do fall, someone is there." Another relative felt confident in the safety of their relative and explained, "[Person] is mobilising better here than at home and they know there is always someone about if they fall. I feel they are safe here."

Care plans included risk assessments related to people's individual needs and abilities. One person was at very high risk of falls. They had been referred to the GP, falls team and visited by a physiotherapist and assessed as suitable for a walking frame. However, because the person was living with dementia, they often declined or forgot to use their walking frame when walking around the home. To manage the risks, staff were directed to prompt the person to use their frame and check their whereabouts every 15 minutes. Staff followed the risk management plan. Throughout the day we saw that when the person walked without their frame, staff either walked by their side or watched them.

However, some people could demonstrate behaviours if they became anxious or frustrated because of their medical condition. There were no care plans to advise staff what might trigger people's anxieties or the action to take to distract or reduce any frustration or agitation. We looked at the daily records for a person who had recently moved to the home. The records showed this person was becoming more anxious and their behaviours had become more physical towards staff. However, there were no plans or risk assessments that informed staff how to support this person and what techniques or approach worked well. Staff told us how they supported this person and there was clearly a difference in the approach different staff explained, which had potential to cause further distress. Another person's relative told us that when anxious, their family member became a lot calmer when they were offered a video to watch. They told us this was known by staff who previously worked in the home, but they were not sure whether new staff knew this. The information was not recorded in the person's care plan. The manager confirmed, "There is nothing that details the triggers or how we can calm people down and distract them." They said this had been identified and was included on their service action plan.

Some improvements were needed when staff recorded the actions they had taken to manage identified risks. For example, some people were on food and fluid charts because they were at risk of not eating and drinking enough. These were not always consistently completed and lacked detail to give a good picture of people's nutritional intake.

Other risks within the environment such as uncovered radiators which were very hot to touch, incorrect window restrictors and building materials stored in a bathroom had not been identified as a potential risk to those living and working in the home. In one shared room, a person's TV was on top of a bedroom side table, posing a risk of injury as it was very close to the person's pillow. When we pointed these issues out, the provider took immediate action. For example, the building materials were removed and new radiator covers

were ordered.

During the day there was one senior and two care staff on shift. They were supported by a cook and the manager. A housekeeper kept the home clean four days a week and care staff covered the shifts on the other three days as part of their normal duties. The manager said, "This is not ideal," but felt it did not impact on the quality of care and support people received. The manager explained that staffing levels were based on people's risks and abilities as identified within their care plans. They felt confident staffing levels were safe, although they accepted staff had extra demands on their time because of the complex emotional needs of a person who had recently moved to the home. The provider was talking with the person's social worker to discuss the level of support this person required.

During our visit there were enough staff to keep people safe, although in the morning they were too busy supporting people with personal care to be responsive to people's emotional and social needs. In the afternoon staff had more time to spend with people outside the delivery of care tasks. Staff did not raise any concerns about staffing levels and said the manager helped out if people needed extra support or more of their time. One staff member said, "With three staff, it's okay, but it depends because we don't always have time to talk with people." However, staff said people were still able to do the things they wanted to do, such as walk around the home and gardens.

People and relatives told us there were enough staff and one person told us they felt safe because, "There are always people here." A visiting healthcare professional told us that when they visited, "You can always find a member of staff."

People were safe because staff told us they received safeguarding training and understood the signs that could indicate a person was at risk of harm or abuse. One staff member shared concerns with us that in the past, people were not always treated as they should be. This staff member said they had reported their concerns to the previous management team, but felt no action had been taken as a result. They said if this happened again, they would continue to raise concerns with the manager, provider, safeguarding, CQC and the police until they were confident action had been taken. This staff member was confident the new provider and manager would take action to keep people safe and said, "People are safe here because we have better carers (staff)." Another staff member said, "I have not seen anyone mistreated. If I did, I would report it to safeguarding."

The provider's recruitment process included making all the pre-employment checks required by the regulations, to ensure staff were suitable to deliver personal care. A new member of staff confirmed they had to wait for the checks to be completed before they were able to start working in the home.

Most medicines were delivered in 'blister' packs', colour coded for the time of day, with an individual medicines administration record (MAR), which minimised the risk of errors. Only trained and competent staff administered medicines. The MAR sheets we reviewed showed most medicines taken were signed as 'administered' in accordance with people's prescriptions. However, care staff applied some prescribed topical medicines during personal care. Topical medicines are those applied directly to the skin. The sheets to confirm these had been applied were not consistently completed which meant the manager could not be sure people always received their topical medicines as prescribed.

Some people were on respite care and staff had handwritten their MAR charts. These were signed by the member of staff and a second member of staff to confirm the medicines, dosage and supporting information had been transcribed accurately. Some medicines were given on certain days of the week, and MAR charts were clearly marked to ensure they were only given on those days.

However, we found improvements were required to ensure medicines given covertly, that is without people's knowledge, were given safely. One person had their medicines crushed and put in their food or drinks. However, the administration instructions for one of their medicines stated, "Do not crush or chew. Dissolve under the tongue." The manager could therefore not be sure the medicine remained effective once it had been crushed or whether crushing it affected the rate of absorption into the body. Whilst the decision to give two people their medicines covertly had been agreed with the doctor to be in their best interests, we saw the letters of confirmation were dated 24 February 2016 and 28 January 2016. The manager told us the need for covert medicines should be reviewed with the doctor on a regular basis and said they would arrange for this to be done.

Where people were on medicines which were prescribed on an 'as required' basis for anxiety, agitation or pain for example, there were not always clear guidelines in place as to when these medicines should be given. The provider did not use a pain assessment tool to assist in identifying when those people who were unable to verbally communicate were in pain. This meant staff did not have the information necessary to enable them to make a decision as to when to give these medicines safely and consistently. The manager told us this had been identified during a recent visit by the home's pharmacist and we saw this was on their list of actions to complete.

The home was clean and staff understood their roles and responsibilities in relation to infection control and hygiene. Supplies of personal protective equipment such as plastic aprons and gloves were readily available to staff in different areas of the home and we saw staff wearing them. One member of staff coughed into their glove and immediately changed into new ones in accordance with good hygiene practice. A visiting healthcare professional told us they had never had any concerns over the cleanliness of the home.

The manager analysed accidents and incidents on a monthly basis, but the analysis needed to be more detailed. For example, the analysis identified people who were at high risk of falling and ensured appropriate action had been taken to minimise the risks to that individual. However, there was no analysis of where people had fallen in the home or at what time they had fallen to identify any trends or patterns at service level that might require action to be taken.

The provider had procedures to manage risks in the event of an emergency. People's care plans included personal emergency evacuation plans (PEEPS), which described the support they would need to evacuate the building in the event of an emergency. The provider had obtained an external fire risk assessment of the premises to ensure their plans for managing the service in the event of a fire were adequate and minimised risks to people's safety. The provider was working through the identified actions following the assessment and had replaced two fire doors and the ceiling in the boiler room.

Good

Is the service effective?

Our findings

People and relatives told us staff had the right skills and attitude to support them effectively. One relative told us, "You get the feeling it's right."

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 so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider completed mental capacity assessments for people's understanding and memory, to check whether people could weigh information sufficiently to make their own decisions or whether decisions would need to be made in their best interests. The assessments were decision specific, but the records lacked detail about how decisions were reached and what was discussed. Best interest decisions recorded the outcome, but again there were no records that showed how the decision was reached. The records we looked at had been completed under the previous provider.

The manager acknowledged that some work was needed on the 'best interest decision' paperwork that was in place under the previous provider. They assured us that in future the records of such decisions would be more detailed so the views of those closest to people were recorded. They also told us they were going to ask for copies of the court documents that gave relatives the right to make decisions on behalf of people, to ensure they had the legal right to do so.

The provider understood their responsibilities under the Act. Where restrictions on people's liberty had been identified, the appropriate applications had been submitted to the authorising authority. However, we had received information that recently, in order to keep people safe, staff had not acted within the principles of the MCA and people's liberty had been restricted. The provider acknowledged that staff had been given guidance by a staff member who no longer worked at the home, which conflicted with the spirit of the legislation. They were confident such a situation would not arise again. They told us lessons had been learnt and they had received advice and guidance from the local authority. Staff were due to complete further training on the MCA and DoLS and a 'reflective practice' meeting was planned to discuss how similar situations could be better handled in the future.

Staff explained the MCA and how they used their knowledge to support people in line with their choices or known preferences. Staff said it was important to offer choice even if people could not always remember. One staff member told us, "You encourage them to do as much for themselves as they can and you give them choices. When they get up in the morning, you don't just get their clothes out of the wardrobe, you give

them a choice." Staff said they referred to people's care plans or other staff if there were doubts over a person's decision making ability.

Staff used different methods of communication to ensure people consented to the care they received. For example, one staff member said when they provided personal care to people who may not understand, they always explained visually what they were going to do. They told us they pretended to wash themselves, and that in most cases they got a 'thumbs up' to go ahead. If this was not successful, they waited and tried again, or got another staff member to help. One staff member explained, "You would go out the room, give them a few minutes and then go back in and try a different approach." Staff said in the majority of cases, this worked well.

People's needs were assessed when they moved to the home and they were also offered the opportunity of a 'trial period'. This meant the provider could be assured they could meet the person's needs and the person settled into the home. However, one person had recently been accepted into the home to facilitate an urgent discharge from hospital. The provider told us they had taken learning from the discharge, because it was clear that due to the person's complex emotional needs, Field View was not the most appropriate placement for them. They explained how they were going to improve the assessment process so they had a better picture of people's needs throughout the day. For example, some people can become more anxious and agitated later in the day, a reaction commonly referred to as 'sundowning'. The provider told us they planned to assess those people later in the day and explained, "If we can meet their needs at their worst time of day, we will be fine when they are at their best."

The provider had introduced an induction programme for new staff. This included each new member of staff being assigned a mentor to support them as they became familiar with the people who lived in the home, as well as their role and responsibilities. The provider told us they had only employed staff who already had health and social care qualifications and experience of working in a care environment. However, if they employed staff new to care, they told us they would provide them with training in the fundamental standards of care, as set out in the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life.

The provider had a programme of training to ensure staff refreshed their knowledge and kept their skills up to date. The provider told us that although staff had received training prior to them taking over the home, records did not always evidence this. They had therefore introduced a new training provider which offered a range of courses and topics through e-learning. Staff were asked to complete two courses each month and the provider told us they checked staff were implementing the training into their practice through, "Supervisions, observations and record keeping."

Staff said they received training relevant to supporting people in their care and felt they had the knowledge to support people effectively. They also told us they were encouraged to take qualifications in health and social care and to take on more responsibility to develop their role in the home. One staff member said, "I have done lots of training, such as first aid, safeguarding, dementia and moving and handling." They explained they found the training useful to help them support people saying, "I know how to use a hoist (when transferring a person)." Another member of staff commented, "[The provider] is red hot on us doing training. There is always some training we need to go on."

People told us the meals were good and they generally had a choice. Comments included: "Food is not too bad at all" and, "They are fed very well; the food is good."

At lunch time most people chose to eat in the dining room, but were not given a choice of what they wanted

to eat. When we discussed this with the cook they told us, "They do normally have a choice, but it was a bit of a rush today." Despite this, the meal smelt appetising, portions were of a good size and nobody declined their meal. Staff supported people to eat, and encouraged those who needed prompting.

We looked at the menus for the week of our visit and found there could be more variety with the choices offered. We discussed this with the provider who told us they had recruited a new cook who had been working in the home for two weeks. They told us they were going to devise new menus with the cook, looking at both the quality and choice of food. They also planned to seek input from people and their relatives to ensure the new menus reflected people's likes, dislikes and preferences.

People's care plans included information about their dietary needs and allergies and how they needed their food prepared to maintain their health. Staff could check people's specific nutritional needs by reading their care plan. The manager told us they planned to introduce an overview of people's nutritional needs so kitchen and care staff could see at a glance people's dietary needs and how they required their food to be prepared and served.

People's care plans included information about their individual medical conditions and health needs. People were supported to obtain advice from their GP when their health needs changed. One person told us when there had been a change in their health, "The doctor was called to see me the same day." Relatives told us they received feedback from any healthcare visits their relations received. A visiting healthcare professional told us they had no concerns about the care of the people they supported in the home.

The home was built on two levels with some bedrooms on the ground floor and some on the first floor. There was a lift to the first floor, for people who did not want to, or were unable to, climb the stairs. There was a separate dining room with a seating area at one end and another large lounge overlooking the gardens. We saw people chose which communal rooms they spent time in. Most people chose to remain in the dining room during the morning and moved to the lounge in the afternoon, where shared activities took place. There was a large garden, parts of which were easily accessible and one person spent time walking around it at various times of the day.

However, environmental challenges in accessing two communal toilets on the ground floor meant some people, who used walking frames, could not access them freely and easily close the door. On three occasions we saw people used the toilets without closing the door. The provider was aware of these challenges and said they were considering a number of options so they could ensure people could access toilets without compromising their privacy and dignity.

The provider was working on a refurbishment programme within the home to provide a safer and more suitable environment for people who lived with dementia. The worn carpets had been replaced with a non-slip floor covering and the bathroom had been refurbished with a bath chair which made the bath more accessible. The provider had painted bedroom doors on the ground floor different colours and intended to introduce memory boxes outside people's bedrooms. This was designed to promote people's independence and enable them to identify their own bedroom door. The bathroom, shower room and toilets had signs on them, but the provider told us they planned to introduce more picture signs to help people orientate and find their way around the home.

Good

Is the service caring?

Our findings

People told us the staff were kind, caring and approachable and were complimentary about the support they received. One relative told us, "It's not home, but it's the next best thing." They went on to say the most important thing was the feeling their family member was, "Well looked after and loved." A visiting healthcare professional told us they found staff to be, "friendly" and "helpful".

The provider was keen to promote a caring environment and led by example. During our visit we saw the provider knew all the people by name and took time to speak with them on an individual basis. When one person became anxious, they spent time talking with them and giving reassurance. One relative told us their family member enjoyed chatting with the provider and felt relaxed in their company.

Staff told us recent managerial changes had a positive impact on their wellbeing and meant people received better care. One staff member told us, "I love it here, I love this home. There is a different atmosphere now and there is so much potential." They said the new provider and manager had made a difference saying, "It's the little things….painted doors, activities always on offer and people do what they want." They also said, "Staff are here because they want to be – no one is on auto pilot."

Staff told us of the qualities they had, which demonstrated they had the necessary skills and attributes required of a 'good' care worker. One staff member said, "I am patient, I love looking after them and I think I have a special bond with them." We saw this demonstrated during our inspection visit with staff being kindly and compassionate in their approach. One person required constant reassurance and engagement from staff to prevent their anxieties escalating. Staff responded to the person's requests and questions with patience, even when the person's anxieties caused them to become verbally challenging. One staff member provided the person with physical and verbal reassurance. They stroked the person's arm and said, "Calm down and take some breaths, you are getting all anxious."

Relatives told us staff took time to know people, develop relationships with them and understand them as individuals. One relative told us staff brought their family member a particular brand of take-away chips because they knew their relation liked them. This person also suffered with back pain and their relative explained, "The care staff bring them hot water bottles as the heat helps."

Prior to our inspection visit, we had received some information that people were not always receiving appropriate personal care. During our visit we saw people were all dressed in clean clothes without any stains and in a style of their choosing. One staff member explained, "The care here is brilliant. We make sure they are clean, and we persuade them if we know they need our help." Staff said people received care from a gender of staff they preferred to help them feel comfortable and relaxed when personal care was provided. One staff member told us, "Receiving personal care is a very personal time and you have to respect that. You just make sure they are comfortable and talk to them."

Relatives did not have any concerns about people's appearance. One relative told us, "The care staff always make sure [Name] is looking nice with their hair and makeup done." A visiting healthcare professional told

us that when they visited, people looked clean and well cared for.

Care staff recognised and respected people's diverse needs and promoted their independence. One member of staff explained, "Their needs may be different to mine, but they are all equal."

Staff encouraged people to do as much for themselves as possible and supported their right to choose where they wanted to spend their time. Staff encouraged people to socialise, but respected their right to spend time on their own if they chose to. Staff respected people's private space and knocked on their doors before entering. However, in a shared room we saw the privacy curtain did not reach the floor. We brought this to the attention of the manager who assured us they would take action to ensure both people had all the privacy they required.

Relatives told us they could visit anytime and staff were understanding of their role in people's lives. One relative told us of an occasion when their relation had become upset. Care staff had called the relative so they could chat with the person over the phone which had helped them to relax. This relative also told us they could bring their relation's dog to visit whenever they wished which cheered the person up and helped their emotional wellbeing.

Requires Improvement

Is the service responsive?

Our findings

People told us they were cared for and supported in the way they wanted and that staff were responsive to their needs. One relative told us, "They are responsive to problems, it's like a big family, everybody has been really nice. They have made us feel very welcome and want to know if you have any concerns."

Each person had a care plan which contained the basic information staff needed to meet people's needs safely. However, some care plans we looked at needed additional information to help staff respond to people's emotional needs and provide consistent care and support. For example, one person moved to the service on 1 March 2018. There was no care plan to ensure staff responded in a consistent way to the person's behaviours. We were told and saw this person was very anxious and agitated, which impacted not only on their wellbeing, but the wellbeing of other people in the home. Staff recorded regular observations of the person, but were not recording their interactions with them to identify those that had a positive impact on the person, or those that did not work effectively. Important information such as this could help formulate a care plan that would guide staff in how to respond to this person's needs.

The manager told us care plans had been improved, but improvements were still needed. They explained the plans needed to focus more on people's whole life so the care they received was centred on their likes, dislikes and preferences. They told us they were introducing a new system which meant senior staff who had developed a relationship with people, would be involved in developing their care plans. They told us this was a vital move in providing person centred care because, "At the moment I wouldn't be able to care for somebody through reading the care plans." A senior member of staff spoke positively about the planned changes. They told us, "The manager encourages us to have more to do with care plans. Now they will be updated as soon as people's needs change rather than once a month, which means we will be more on the ball with changes."

The Accessible Information Standard (AIS) aims to make sure that people who have a disability, impairment or sensory loss get information that they can understand and any communication support they need. Care plans did not contain specific information about people's communication needs, but staff communicated effectively with people because they knew them well.

Staff shared information about changes in people's needs at a verbal handover between shifts. This information was also recorded in a 'handover folder'. This ensured information was not lost and staff could refer back to see what they had missed if they had not worked for a couple of days.

We found people had some end of life care arrangements in place. The arrangements included decisions that had been made regarding whether people should be resuscitated following a cardiac arrest. There was also some information about what people wanted to happen after death. However, there was no recorded information in people's care plans about their wishes and expectations for being cared for in their final days. The manager acknowledged this was an area where improvements were required. They told us nobody was on 'end of life care', but if a need was identified, they would liaise with the GP, district nurse and local hospice to ensure people had the medication they needed to keep them comfortable and pain free. Staff

were due to complete training in end of life care, but in the meantime felt they had the understanding to support people as they became more poorly. One staff member told us they would, "Give them respect and compassion. You make sure they are comfortable and talk to them."

During the morning staff were busy and there was limited opportunity and stimulation to keep people who did not have capacity to engage in anything independently, occupied and interested. A number of people sat in their chair looking around; others fell asleep in their chairs. A couple of people walked around the home and garden area. One person kept themselves occupied with knitting and told us how they enjoyed looking out at the garden to see the birds and wildlife. Another person told us they preferred to spend time in their bedroom where they had a good view of the garden and woods backing onto the home. They had a desk under the window where they spent most of their day drawing and colouring.

During the afternoon, staff had more time to spend with people. One staff member played a music cd and some people joined in singing old classic songs. People started dancing with the staff member which their smiles, showed they clearly enjoyed.

The provider told us they were starting to, "Look at people's reactions and gauge their responses" to ensure the activities offered were meaningful to people and provided them with opportunities to maintain and share their individual interests. A member of staff had been identified to take the lead and was working on developing the programme of activities. Staff confirmed the opportunities for social engagement in the home were improving and appreciated how this supported people's emotional wellbeing. One staff member described how important it was for people to have those moments of pleasure and enjoyment. They told us, "In that moment they are loving it. For that moment they are fulfilled."

The complaints procedure was made available in the service user guide given to people when they moved to The Field View. All the people we spoke with said they had 'no complaints' about the service. They told us they would be comfortable to make a complaint directly to the manager or provider if they wanted to complain about anything. The provider had not received any formal or written complaints since they took over the home.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were happy with the care provided at The Field View Residential Home. They spoke of the visibility of the provider and manager and felt involved in making decisions about their family member's care.

The provider took over the service as a 'going concern' in July 2017and had identified improvements were needed within the home. They told us of the challenges they faced at that time. "When we started, staffing levels were very low and there was a very high use of agency staff, which is very expensive and not in the best interests of residents as they don't get continuity of care." They told us their first priority was to recruit new staff and were pleased they now had a full complement of staff with negligible use of agency staff. They went on to explain, "The home was a little bit lost and the procedures were a bit dated. I decided I would make the changes slowly and well rather than rushing. I also had to reassure the staff and steady the ship."

Since the provider had taken over the home, the registered manager, deputy manager and some staff had left. The provider had recruited a new manager and a deputy manager. The manager had been in post for eight weeks at the time of our visit, and the deputy manager was due to start in the middle of March 2018. Although the provider acknowledged this had been a challenging time, they felt the 'fresh eyes' of the new management team would improve the culture of the home and drive the improvements required, so people who lived there had better outcomes.

The new manager told us their biggest challenge was, "Getting on top of the audits." They said the previous registered manager had left suddenly and as a result, they had not had a handover. They told us this meant they had to respond more 'reactively' to issues, rather than having a planned approach. They said this would improve in time.

Due to the lack of formal handover between managers, we found some systems and checks that kept people safe and protected were not always effective. Environmental risks were not monitored and in some cases, not considered a risk by staff or the management team. For example, a radiator in a communal corridor was too hot to touch and a vacant room we used during our visit, showed the temperature was close to 100 degrees. We saw one person was in bed and their bed was against a radiator. This radiator was covered, unlike other radiators which remained uncovered. Daily checks on pressure relieving mattresses had not identified that they were not regulated dependent on people's weight, as guidelines recommend. For example, one person's mattress was set at 80kg when they weighed 66kg.

Care plans were inconsistent and in some cases, incomplete. Speaking with staff showed us they used different approaches which did not provide people with the right support to manage certain behaviours to stop them from escalating. MCA assessments were decision specific, but there was a lack of records to show how the best interest decision was reached and who was present, such as family or advocates. Guidelines to support good medicines management were not always in place.

Staff explained to us the challenges they had faced before the provider took over the home. In some cases,

they felt their voice was not heard as the previous provider's actions had not led to improvements and supported a culture that one staff member said, "Was awful, unprofessional and the CQC reports reflected that." This staff member told us the new provider and new manager had improved the atmosphere and culture at the home and said, "Now I love it, there is so much potential." They said they enjoyed working at the home and felt the care people received was much better.

The provider was working closely with the new manager to raise standards, keep people safe and motivate staff. They had planned for staff to have the training they needed to support people and staff were being given opportunities to discuss their performance and development. The provider had looked at the working environment and staff had been given their own area in the home so they could benefit more from breaks during their shift.

Staff spoke highly of the commitment and motivation of the provider. They told us the provider visited the home regularly and took time to understand the service, the people who lived in the home and the staff who worked there. Staff said the new provider had dealt with staff attitudes and bad practice which meant a number of staff had left. Staff said the provider was interested in their views and welfare and said if there was anything they wanted to raise, they could contact the provider without prejudice. Staff said they welcomed this open approach which ensured actions could be taken swiftly to make improvements to the service people received. One longstanding staff member told us the home 'had changed for the better' and said, "The provider is spending more on the place so it is more comfortable for the residents and putting more things on for them. This is his baby and he is very motivated." This staff member also told us, "He sees me like a person rather than just an employee." Another staff member told us, "The provider is a lovely man, approachable and asks us what we think."

Staff also spoke positively about the new manager's attitude and the processes they had already introduced to make the service safer. One staff member told us, "I think he has brought a lot of good ideas to the table. He is very good and hands on. That is what I like about him. He put in place that if anyone has a fall, we have to monitor them every hour for 24 hours." Another idea to keep people safe was to personalise people's walking frames so people could identify them easily, which acted as a prompt to use them. We were told the introduction of this scheme had already reduced the number of falls in the home.

Staff attended regular staff meetings where information about changes was shared. Staff felt encouraged to make suggestions about how the service could be improved for the benefit of people. One staff member explained, "[Manager] has asked us to bring more ideas so we can change things to add to the activities." When we asked whether the management team were responsive to their suggestions, they responded, "They do take them on board and I appreciate that." In turn, the manager felt the staff were beginning to work together more effectively as a team. They spoke about the week before our visit when heavy snow affected the accessibility of the home. They told us staff worked together to ensure shifts were covered and people's needs continued to be met.

The provider was introducing new ways to engage people and relatives in the community of the home. They had instigated a regular newsletter which gave people information about any changes in the home, the staff team and planned activities. The provider also encouraged people to provide feedback and to share their experiences of the service in ways which suited their needs and preferences. People were invited to attend meetings and social events where they could gain a better understanding of how the home was run and share their opinions and suggestions. For those people unable to attend such events, the provider had given people his telephone number and email address so they could contact him directly to share any feedback or concerns.

People had also been invited to complete questionnaires when they visited the home. People's feedback results for 2017 were displayed in the communal hall. These results showed people were pleased with the service provided with 100% being happy with the friendliness of carers and 97% commenting favourably about their views being listened to. However, only 84% were happy with the facilities of the home which demonstrated there was room for improvement. The provider had taken action in response. A planned refurbishment programme was underway and the provider told us they were committed to improving the environment for people.

The provider had invited external scrutiny of the home to identify where improvements were required. For example, they had invited the pharmacist to review their medication procedures and had started to implement a programme of improvement to ensure people always received their medicines as prescribed.

Prior to our visit we had been made aware of a safeguarding incident in the home which the provider and previous manager had not informed us about in accordance with their regulatory responsibilities. The provider told us this had been a matter of miscommunication within the home and assured us that both they, and the new manager, had a good understanding of their legal obligations under the Health and Social Care Act 2008 and associated regulations.