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Field View

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 31 January 2017 and was unannounced.

Field View is a residential home which provides care to older people including some people who are living with dementia. Field View is registered to provide care for up to 20 people. At the time of our inspection there were 15 people living at the home.

There was a registered manager in post. 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.

At our previous inspection in May 2016 we found breaches of the regulations related to managing risks to people's safe care and treatment, staffing levels and the governance of the home. We also identified the provider's registration status with us had not been updated to confirm that there was now only one owner with responsibility for the registered regulated activity at the home. This meant the provider's' registration status with us was not correct which was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our visit, the provider sought professional advice regarding the registration of a new legal entity. The registration was completed at the beginning of December 2016 which meant the service was appropriately registered in accordance with our registration regulations and the responsibility for the regulated activity remained with the same person before and following the new registration.

At this inspection we looked to see if the provider had responded to make the required improvements. We found sufficient improvements had been made to meet the regulations previously breached. However, we identified some incidents in the home had not been recognised as potential safeguarding issues that should have been reported to us and the local authority safeguarding team.

People and their relatives were confident they received safe care and support from staff who knew people well. Staff were available to respond to people's requests for assistance, and there was always a member of staff in the lounge area where people sat during the day. Care plans did not always include detailed risk assessments, but staff were knowledgeable about people's individual risks. Staff understood their responsibilities to report any concerns they had about people's health or wellbeing. The character and values of staff were checked prior to employment, to ensure they were of a suitable character to work with people living in the home.

Medicines were stored safely, but improvements were required to ensure medicines were given in accordance with people's prescriptions.

Staff were encouraged to keep their training and skills up to date and had regular meetings with their

managers to discuss their role and any training or development needs.

The registered manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests. Staff understood and acted within the principles of the Act to support people to make their own decisions.

People were offered food that met their dietary needs. People were encouraged to eat their meals and offered regular drinks to maintain their hydration. People were supported to access medical professionals when they needed to. Relatives were kept informed of any changes in their family member's health.

People were cared for by staff who were kind and caring and who acknowledged the importance of respecting and ensuring people's privacy was maintained. Staff had a friendly approach to people and were responsive to their needs. Staff understood the value of knowing people's personal history and of engaging people in conversations that were meaningful. People were able to choose how they spent their day and were supported to socialise or spend time alone, according to their preferences.

Care was planned to meet people's individual needs and abilities, although care records were not always up to date. However, staff were able to respond to how people were feeling and to their changing health or care needs because information was shared with them between shifts.

The provider had taken action following our last inspection visit to address the concerns we identified. Improvements had been made to the management of risks around people falling and action taken to ensure the environment was safer for people and environmental risks managed. However, some audits to monitor the quality of care provided needed to be implemented more effectively and consistently to identify areas where the service could improve.

We found a breach 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 the report.

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 how to safeguard people from harm or abuse and there were enough staff available to care for people safely. However, the registered manager had not recognised some incidents and accidents as potential safeguarding issues and referred them to us and the local authority as required. Written care plans did not always record the actions staff should take to minimise people's individual risks. Improvements were needed to ensure people were always given their medicines as prescribed. The provider recruited staff of good character to support people at the home.

Is the service effective?

Good

The service was effective.

Staff had the training, skills and experience to meet people's needs effectively. The registered manager and staff knew how to support people in line with the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) so that people's rights were protected. People received food and drink that met their preferences and maintained their health. People were supported to access medical professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well as individuals. People had their privacy respected and staff supported people to maintain their independence. Staff did not rush people and took time to listen to and understand people with limited verbal communication. People were involved in making everyday decisions.

Is the service responsive?

Good

The service was responsive.

Staff supported people to spend time engaging with staff, socialising with others or alone, according to people's needs and preferred routines. Care records did not always capture changes in people's needs. However, staff knew people well and shared information about changes at verbal handovers between shifts and a written communication book. People were able to raise complaints about the service, and the provider had procedures in place to learn from, and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management team were approachable and there was a clear management structure to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. The provider had implemented a series of audits which had resulted in improvement to the quality monitoring system. However, further work was now needed to ensure the audits were implemented effectively and consistently.

Field View

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 was 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 service was last inspected in May 2016 when we found the provider was not meeting the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvement was required for the service to be Safe, Effective, Caring, Responsive and Well Led. At our comprehensive inspection in January 2017, we found improvements had been made, but further improvements were required. This was our first inspection since the change in registration,

The inspection visit took place on 31 January 2017 and was unannounced. The inspection was conducted by two inspectors.

Prior to the inspection visit we reviewed the information we held about the service. We looked at information shared with us by relatives and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We contacted the local authority commissioners to find out their views of the service provided. Commissioners are people who contract care and support services paid for by the local authority. They had no new information to share about the service.

We spoke with five people and two relatives about what it was like to live at the home and a visiting healthcare professional. We spoke with three care staff and the cook about what it was like to work at the home, and one member of staff who worked nights sent us information via email after our inspection visit. We spoke with the provider, the registered manager and the deputy manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool

(SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed two people's care records to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Most of the people living at Field View were unable to tell us in detail if they felt safe living at the home due to their limited ability to communicate. However, all the people we spoke with indicated with nods or gestures they felt safe. Where people were able to speak with us, they confirmed they felt safe living at Field View. One person confirmed this saying, "I don't want to leave here." One relative told us they were confident their family member was safe and explained, "Staff are constantly checking [person]. They are always popping in to see him and monitoring his food and fluids."

The provider had a safeguarding procedure to guide staff on how to protect people from harm. Staff understood their responsibilities to keep people safe and protect people from the risk of harm or abuse. They understood the type of concern they should report and how to report it. For example they told us they would look out for changes in people's behaviour or any bruising that could not be explained. One staff member told us, "People might be aggressive or get angry or they could go the other way and become withdrawn."

Information about the local authority safeguarding team was displayed so people and visitors to the home had a contact number if they wished to raise any safeguarding concerns externally.

However, during our visit we looked at accident and incident reports and identified occasions when people had been pushed over or hit by others which had not been reported to the local authority or ourselves as potential safeguarding incidents. For example, on 7 July 2016 one person had a verbal exchange with another person and pushed them over causing that person to bang their back and head on the floor. The person had been taken to hospital by ambulance because of the injuries they sustained. Similar incidents had occurred on five different occasions between August and December 2016. None of these incidents had been reported as safeguarding issues. It is important such incidents are reported to keep people and others safe when they demonstrate behaviours that can cause distress or injury. We also identified two safeguarding incidents that had been referred to the local authority in January 2017. The two safeguarding incidents had not been notified to us in accordance with the provider's legal responsibility.

We found this was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

During our previous inspection in May 2016, the provider had not been providing safe care to people, and we judged they were in breach of Regulation 12. At that inspection we were concerned the registered manager had not taken positive action to see why people who were identified as being at risk of falls, were falling, and what interventions could be taken to minimise the risk of further falls and potential injuries. At this inspection we found the registered manager had made improvements to the management of risks around people falling at the home.

Falls were recorded and there was evidence of action that had been taken to minimise further risk of falling. For example, one person who was at high risk of falls had been referred to the GP, falls team and a

physiotherapist for a review as to why they might be falling. The physiotherapist had visited the person at the home, observed their movements and recommended that whilst the person did not need any specialist equipment, they should be encouraged to take their time when walking around the home. In November 2016 this person was prescribed a medicine to help manage some changes in their behaviours. The registered manager had asked for a medicine review in December 2016 because they were concerned the medicine was making the person sleepy which was contributing to their risk of falls. The medicine had been adjusted and no falls had been recorded for this person in the four weeks prior to our visit.

Another person had been referred to the physiotherapist because they had fallen several times in their bedroom. The physiotherapist had recommended equipment to keep the person safe whilst maintaining their independence when they were in their room. The equipment was in place at the time of our inspection visit.

The registered manager analysed falls within the home on a monthly basis, but the analysis needed to be more detailed. 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.

Following our last inspection all staff had completed falls awareness training and we saw they ensured people had their walking frames to hand and encouraged them to use them when walking around the home. We asked staff how they would support a person if they fell. One staff member responded, "I would ring the call bell and someone would come and help me. We would assess the resident on the floor and if they were not hurt then we would assist them back onto a chair. We would fill in an accident form and share it at changeover that they had had a fall."

When we visited the home in May 2016 we found some health and safety issues that could have potential to cause serious injury. At this visit we checked whether environmental risks to people were being managed and mitigated. We found the provider had taken action to ensure the environment was safer for people. Checks were undertaken regularly on water temperatures, gas equipment and electrical equipment. Records showed regular checks were in place to monitor water for infectious diseases such as legionella. There were restrictors to prevent windows on the first floor opening wide enough for people to get through. Rooms where cleaning equipment and chemicals were stored, such as the sluice room, were kept locked so they were not accessible to the people who lived in the home.

At our last inspection we were concerned that staff levels and the dependency needs of the people impacted on the level of care and support people received, and we judged the provider was in breach of the Regulation 18.

At this inspection people, relatives and staff gave us consistent information about the numbers of staff on duty. Everyone told us they thought there were enough staff to meet people's care and support needs. One relative told us, "My mother was in another care home. There seems to be a lot more staff here and the other home was a lot bigger." They went on to say, "Nothing is rushed. If [person] wants to take half an hour to eat a yoghurt, they will spend half an hour with them." Overall, staff told us they had enough time to support everyone and there was always good cover and support. When asked whether there were enough staff, one staff member responded, "At the minute yes. [Registered manager] has listened to the staff and we have got extra staff. You need that bit of extra time to engage with the residents." Another staff member felt more staff would be helpful because they were often very busy, but said, "I think people are safe, we are aware of people all the time."

We asked the registered manager how they assured themselves there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their needs and their dependency level. The registered manager had already identified the need to increase staffing levels from two members of care staff in the afternoon to three, and this had been implemented. The registered manager told us they intended to recruit an activities co-ordinator to further increase the staffing levels, as care staff currently spent time with people doing activities each day.

We observed there were enough staff during our inspection visit to care for people safely. Staff were available to respond to people's requests for assistance, and there was always a member of staff in the lounge area where people sat during the day. In addition, the manager and deputy manager were available five days a week to offer support in the communal areas of the home when needed. There was an on-call system at weekends if staff needed to contact the managers in the event of an emergency.

People were supported by regular staff who knew them well and who understood their individual risks. However, some care plans did not include detailed risk assessments, or detailed explanations for staff about how to support people safely. For example, we saw one person had a stoma. A stoma is an opening on the surface of the abdomen which has been surgically created to divert the flow of faeces or urine. Stoma sites require regular cleaning to ensure they do not become infected. There were no risk assessments or records in place to instruct staff in the cleaning and monitoring of the site and associated equipment.

One person was at risk of developing damage to their skin as they were cared for in bed. The person was being seen daily by the district nursing team to care for two wounds to their skin. However, there was no written risk assessment or care plan to instruct staff on how they should continue to care for the person's skin during personal care. Staff had been instructed to re-position the person every two hours to prevent further deterioration to their skin. We found the re-positioning records were not being kept up to date. For the two days prior to our inspection visit the person's records showed they had only been re-positioned five times in each 24 hour period. However, staff we spoke with had a good understanding of the risks related to this person's care. One member of staff told us, "We know about the risks to people. We know [person] needs to be re-positioned every two hours. Staff are doing this, it's just the records aren't always kept up to date." They added, "The person's wound has been improving, the nurses only need to visit every other day now."

Medicines were stored safely in locked medicines cabinets in each person's room and stored at the recommended temperature to ensure they remained effective. Everyone had an individual medicines administration record (MAR) with their photo, to minimise the risk of errors. Records showed staff signed when people's medicines were given and recorded when people declined to take their medicines.

However, we found improvements were required to ensure medicines were given in accordance with people's prescriptions. For example, one person was prescribed a medicine that needed to be given 30 minutes before any food items containing caffeine. A senior member of staff confirmed the person was given the medicine with a cup of coffee in the morning. Another person received their medicines 'covertly'. A senior staff member told us the person's tablets were crushed and put in their food or drinks. The decision to give this person their medicines covertly had been agreed with the doctor and family to be in the person's best interests. However, the administration instructions for one of their medicines stated 'Swallow the medicine whole. Do not chew or crush'. We 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. We raised this with the registered manager who immediately contacted the person's doctor for a medicines review.

One person was prescribed a medicine 'when required' for agitation. There was no protocol to advise staff

when this medicine should be given. Following our inspection, the registered manager sent us a written protocol so staff had the information they needed to ensure the medicine was given safely and consistently.

The provider's recruitment process ensured risks to people's safety were minimised. The character and values of staff were checked prior to employment, to ensure they were of a suitable character to work with people living in the home. Records showed new staff had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

The provider had a whistleblowing policy and procedure which meant staff knew they could share concerns about other staff's practice in confidence. This was displayed in the entrance to the home so it was always available to staff. Staff told us they would be confident to 'whistleblow' because it was an important part of keeping people safe.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as a gas leak or flood were planned for so any disruption to people's care and support was reduced. Contingency plans were in place to accommodate people at a different site whilst the building was made safe.

However, we were not satisfied that the risks to people in the event of fire were being consistently managed. There were no instructions to guide staff how people cared for in bed should be evacuated. The registered manager assured us they would take immediate action to make sure staff had the necessary information to support people safely in the event of a fire.

Good

Is the service effective?

Our findings

Relatives told us staff had the skills they needed to support people effectively. One relative told us they had observed occasions when people had become upset or anxious. They told us staff dealt well with the situation and said, "They (staff) were very calm and respectful as well."

Staff told us they received an induction when they started work which included working alongside an experienced member of staff. Induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was following the latest guidance on the standard of induction.

Staff told us the manager encouraged them to keep their training and skills up to date. Comments included: "It is very good. It is continuous course work and they give you opportunities for extra training" and, "[Registered manager] keeps a book so she knows when everybody needs to do their training." Records showed that since our last inspection visit in May 2016, staff had completed further training in areas such as infection control, fire safety, caring for people living with dementia and end of life care.

Staff used their skills effectively to assist people at the home. For example, we saw people being supported to move around with the use of walking frames. Staff encouraged people to use the equipment when they were unsteady when walking alone.

Staff told us they were supported with regular meetings with their manager to discuss their role and any training or development needs. Comments included: "They (managers) mainly ask if I want any training or have any concerns" and, "It is good because if you have got any concerns you can raise them, but I would go and speak to the managers straightaway if I did have any concerns about anything."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered manager 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 registered manager had reviewed each person's care needs to assess whether people were being deprived of their liberties. Several people had a DoLS in place at the time of our visit which demonstrated the registered manager had made appropriate assessments in accordance with the MCA. They told us applications for other people had been made to the local authority, which were awaiting authorisation at the time of our visit.

People's care plans included an assessment of their capacity and understanding, but did not always identify exactly which decisions should be made in their best interest and who should make them. For example, mental capacity assessments were in place where people did not have the capacity to understand the risks of them leaving the home on their own. However, other mental capacity assessments and 'best interests' decisions had not always been recorded, for example, for the use of items such as bed rails. In one person's care record a 'best interest' decision about their care had been made by a health professional, but the person's care records stated they had the capacity to make their own decisions. We brought this to the attention of the deputy manager and provider during our visit. They explained the person's capacity had recently changed and they no longer had capacity. The deputy manager updated the records straight away.

The registered manager was aware that the MCA was an area where they needed to consolidate their knowledge and understanding. Both the registered manager and deputy manager were booked on a two day external practitioner's course on the MCA and DoLS in the coming weeks. They were confident the course would improve their practice around the MCA within the home.

Staff had been trained in The Mental Capacity Act 2005 and knew they should assume people had the capacity to make their own decisions, unless it was established they could not. Staff encouraged people to make everyday decisions and supported them according to their known preferences if they were unable to state their decision to make sure any decisions made on their behalf were in their best interests. One member of staff told us how they supported people to make decisions about what to wear. They explained, "I will get two choices, so they get to choose whether they want to be in red or in blue. You don't give them too many choices because that may confuse them, but you still give them a choice."

Staff understood that people's capacity to make a decision could fluctuate and that they should be aware of that when supporting someone to make a decision. One staff member told us, "You have to take into account their moods that day so it (the decision making) would have to be done over a period of time."

Staff asked for people's consent before providing support. One staff member explained, "When I am providing personal care, I always ask first and I explain what I am going to do and ask if it is okay." Staff told us they would respect people's right to refuse support, a typical comment being, "It would have to be documented they had refused and I would go back half an hour later and try again."

At lunch time most people chose to eat their meal in the dining room. People told us the food was good, and they could choose what they wanted to eat. One person commented, "The food is fine here." One relative told us their family member's appetite had reduced because of ill health. They told us, "Because [person] can't eat a lot they will make him what he wants. He likes puddings so they give him extra pudding. They are very good at coaxing him to eat a little bit more and drink a little bit more."

There were enough staff on hand to assist people who needed support when eating. Staff ensured everyone had the opportunity to eat at their own pace, and persevered where people did not seem to want their food. For example, one person was reluctant to eat in the dining room. Staff brought them a tray of food in the lounge area and encouraged them to eat their meal, staying with the person to make sure they were able to assist the person when required.

People were offered food that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet. The chef told us, "I know people really well, so I know who requires a special diet. One person is on a soft food diet, so we make sure their meal is prepared accordingly." They added, "We are kept updated with any changes of people's dietary requirements." A relative told us, "They have been really

good here, when [person's] diet changed they just adapted things for them, they are on a soft diet now."

We saw people were offered hot and cold drinks and snacks throughout the day in accordance with their needs. One person told us they were hungry following the lunchtime meal, staff were nearby and responded by offering them a snack and a hot drink. We saw people had access to drinks in their bedrooms, in the dining areas and in the lounge areas. This supported people with maintaining their hydration.

People were supported to access medical professionals when they needed to. Care records included a section to record when people were seen or attended visits with healthcare professionals and any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, mental health practitioner, physiotherapist and dentist where a need had been identified.

Relevant information about people's health was shared with visiting health professionals. For example, in one person's records staff kept a full record of the amount of fluid and food they had consumed each day. This had been identified as a requirement for the person as they had recently been discharged from hospital where they had lost weight. The records were shared with the district nursing team to ensure the person was eating and drinking enough to maintain their health.

Relatives told us they were always kept informed of any changes in their family member's health. One relative commented, "As a family we are made fully aware of things." Another confirmed, "They are very good at keeping me informed."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind, caring and respectful. One relative said, "The staff really do go the 'extra mile' for people. When we picked [person] up for a Christmas meal the staff had bought them a new dress, they had their hair and make-up done and looked lovely. When we asked if we could pay for the dress, the staff told us we didn't need to. This was really going above and beyond." Another relative told us, "They (staff) are so kind to [person] and treat him like a member of the family."

Throughout our visit we observed positive interactions between people and staff. People appeared comfortable with staff, and we saw staff speaking with people with kindness and respect. Staff altered their communication style to adapt to people's needs, including bending down to speak with people at eye level and sitting down next to them to make them feel comfortable when having a conversation with them.

People made everyday choices about how they spent their time. We saw most people at the home spent time in the communal areas according to their preference, rather than in their bedrooms. When we arrived at the home, some people were up having their breakfast and other people stayed in bed until they were ready to get up. One person told us they didn't want to eat their lunch in the dining room, so staff served their lunch on a tray in the lounge.

One person told us they chose where to spend their time saying, "I like to be in the lounge, there's more company here." They added, "The garden is nice in summer." The lounge looked out onto a well-kept garden with patio area. Other people added their voice agreeing the garden was lovely to see, and was used regularly on nice days.

Staff understood the value of knowing people's personal history and of engaging people in conversations that were meaningful. For example, staff knew each person by their preferred name and called them by this. Staff knew people's background, and whether they had children and grandchildren. One member of staff introduced us to a person who had spent some time in the armed forces. The person was keen to chat with us and tell us about their experiences. One staff member explained why it was important to know about people's background and previous life. They told us, "If you don't, you don't get to know the person and we are all unique."

Staff used tried and tested means of supporting people living with dementia to communicate, such as using short sentences to which people could state their preferences or wishes by answering 'yes' or 'no'. One person's first language was not English. They carried communication cards with pictures, words and simple sentences in both English and their own language on them. This supported staff and others to have simple conversations with the person, ensure they were giving the person choices and respecting the decisions they made. In addition, a list of everyday words in the person's language, and their English meaning were on the noticeboard in the lounge area, to enable people to communicate with the person more easily.

Relatives told us staff did not rush people and took time when supporting them. One relative told us their family member could sometimes be reluctant to take their medicines. They explained, "They are very good

at persuading him to take it in a nice, friendly way. They can talk him round in a caring way."

People told us they were supported to maintain relationships that were important to them. One person said, "My family come to see. It is no problem." Relatives told us, "The home is lovely and homely" and, "We are always welcome when we arrive." We saw people and their visitors were offered drinks and used communal areas of the home which helped to make them feel welcome.

Staff understood the importance of respecting and ensuring people's privacy was maintained. One staff member told us, "This is their home now. This is where they live, so they should be able to treat it as their home." We observed care staff respected people's privacy when entering their rooms. Staff knocked on people's doors and announced themselves before entering. Care records were kept securely at the home, to protect people's confidentiality.

The registered manager told us people were assisted to develop and maintain their independence. For example, most people were mobile and used walking frames to get around the home, unaided by staff. The manager told us that although this meant staff needed to carefully monitor people to make sure they were as safe as possible, it was better for people to maintain their mobility rather than be restricted because of the risk of falls.

Good

Is the service responsive?

Our findings

Relatives felt that the care their family member received was responsive to their needs. One relative told us, "[Person] came for respite care, liked it and decided to stay." They went on to say, "I have definitely felt they know [person], what he can do and what he can't do and they respect that. Nothing seems too much trouble for them and it is nice to see them stopping and speaking to residents."

Throughout our inspection visit we saw staff had a friendly approach to people and were responsive to their needs. For example, one person was calling out to staff and becoming anxious, saying they did not want to go home. Staff responded quickly and sat with the person to reassure them. They chatted with the person about their day to distract them and help them remain calm. Staff reassured the person they could stay at Field View.

Relatives told us they had been involved in putting together people's care plans before they moved to the home. One relative said, "We are always involved. For example we were consulted regarding restrictions on [person's] care." Relatives also told us they were kept informed about their family member's emotional wellbeing. One relative commented, "When [person] was becoming distressed because we were leaving after our visit, staff spoke to us. They suggested we come before lunchtime, and then when [person] has their lunch, we can leave. It means [person] is already doing another activity and is distracted, so they don't get distressed any more when we leave."

Care records were available for each person who lived at the home. Records gave staff information about how people wanted their care and support to be delivered. For example, care records included information on maintaining the person's health, their support needs and their personal preferences where these were known. However, we saw that not all care records were kept up to date. For example, in one person's care records we saw that they were cared for in bed, however, in several places in their care records it documented the person was able to use a walking frame. The deputy manager explained the person's needs had recently changed, but the care records had not yet been updated. We saw in another person's care records that the medicines they were prescribed did not match a list of medicines shown in their care plans.

Although we identified these issues with the records, we found no impact on the care people received as staff knew people's needs well. Staff were able to respond to how people were feeling and to their changing health or care needs because they had a verbal handover at the start of their shift. The registered manager also maintained a staff communication log which each member of staff was expected to read. This documented important information such as changes to people's health, scheduled visits for health professionals, and also information and learning from accidents, incidents and complaints.

People were supported to take part in activities according to their personal preferences. We saw several activities taking place at the home. A member of staff spent time with one person helping them to complete a word quiz. Other people were encouraged to have a 'sing-a-long' to a popular group. People joined in; staff and four people began dancing to the music. Other people, although encouraged to join in, were happy to sit and watch. Later, one person enjoyed a game of catch, whilst another person chatted to a member of

staff about their day. This person told us, "I enjoyed the dancing earlier. I used to go to dance lessons when I was young." They added, "I like it here, it brings back good memories."

One relative told us their family member spent a lot of time in their bedroom, but that staff tried to ensure they did not become socially isolated. They told us, "They are still trying their best to get him in with everybody else, even if it is only for half an hour."

Although everyone seemed to enjoy the activities at the home, people were not always aware what activities were on offer to them. There were two activity plans on display at the home, one showed activities by week and the other by month. We looked to see what activities had been planned for the day of our inspection. The two plans differed and did not describe the 'sing-a-long' or dancing. Staff explained that although some things were planned in advance, they asked people each day what they would enjoy, so activities were arranged in response to people's daily requests.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home and in the service user guide each person had in their room. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One relative told us, "I would probably go to [registered manager] or [deputy manager] in the office. They are all very approachable."

The registered manager had acted on the feedback they received in complaints to improve the quality of their service. Since our last visit in May 2016 the service had received three complaints. One complaint about the standard of care provided within the home was on-going at the time of our visit. The registered manager had carried out an investigation into the concerns and identified that improvements needed to be made in completing documentation, especially daily records. Staff told us the results of the investigation had been shared with them both verbally and through the daily communication book so they understood where they needed to improve their practice.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2016 the provider told us Field View's registration was that of a partnership, however they told us the partnership only consisted of one person and had done since December 2014. This meant the provider's' registration status with us was not correct which was a breach of Regulation 21. Following our visit, the provider sought professional advice regarding the registration of a new legal entity. The registration was completed at the beginning of December 2016 which meant the service was appropriately registered in accordance with the registration regulations.

At our last inspection, we found the provider was in breach of the regulations related to governance of the home. The provider's policies and procedures to monitor and maintain the quality of the service did not meet the requirements of the regulations. During this inspection visit we found sufficient improvements had been made so the provider was no longer in breach of the regulation. The service continues to be rated as 'requires improvement', because, although some action had been taken, other actions had not been fully implemented or they required further work to ensure their effectiveness.

At our last inspection we were concerned the registered manager had not taken positive action to manage the risk of falls within the home. At this inspection we found the registered manager had made improvements to management of risks around people falling. Where people had been identified as being at high risk of falls, they had been referred to the appropriate external healthcare professional and, where recommended, equipment had been introduced to keep people safe without restricting their independence. Further work was needed to ensure any patterns or trends around falls were identified so, where necessary, action could be taken at service level to minimise the risks.

The processes the registered manager used to make sure people received safe and effective care from suitably trained staff had improved. The registered manager had a training schedule in place that ensured staff completed essential training within the provider's timescales.

In May 2016 we found the lack of attention to ensure the environment remained safe for people had potential to place people at unnecessary risk of harm. At this visit we found the provider had taken action to ensure the environment was safer for people and environmental risks were being managed. However, we found some checks needed to be more robust. For example, we identified some infection control issues at the start of our visit. We shared these with the provider who took immediate action. This included the replacement of light pulls, the cleaning of some areas, and the ordering of replacement flooring in one toilet.

Following our last visit the provider had directed the registered manager and the deputy manager to conduct regular quality checks on different aspects of the service. Regular checks included health and safety checks, medicines checks and checks on people's care records. Where these had highlighted any areas of improvement, action had been taken to make changes. However, we identified that further work was now needed to ensure the audits were implemented effectively and consistently. For example, audits of care records had not identified that care plans were not consistently updated when people's needs changed. We discussed this with the provider who confirmed that care plans were written by the deputy manager who

also carried out the care plan audits. They agreed that in future the audits would be completed by the registered manager to ensure it was a more critical and objective process.

There was a clear management structure within Field View to support staff. The registered manager was part of a management team which included a deputy manager. Staff told us they received regular support and advice from the managers to enable them to do their work. Staff told us there was an 'on call' telephone number they could contact outside office hours to speak with a manager if they needed to. The deputy manager also worked alongside staff several shifts each week to keep staff and themselves up to date with what was happening in the home.

Staff told us they felt supported by the managers who they described as open and approachable. Comments from staff included: "[Registered manager] and [deputy manager] are brilliant. They come out all the time if we need help. They are great, really good management" and, "[Registered manager] and [deputy manager] are very approachable. If seniors can't answer a question, staff can go the office and if they are busy, they will make time." Staff also felt the managers cared about the home and the people who lived there. One staff member told us, "The management really care about the residents. They spend hours here and sometimes don't leave until 8.00pm or 9.00pm at night."

The provider had received a recent complaint about the standard of care provided at Field View. Staff told us this had been openly discussed with staff and learning had been shared by the registered manager with the staff team. One member of staff told us, "[Registered manager] told the staff to be more aware and obviously the main thing was documentation. They said, 'if it isn't written down, it hasn't happened' and told us we needed more detail in the daily reports." Another told us, "We were told to make sure we document everything. I think that is where we may have let ourselves down that weekend. [Registered manager] told us we had to make sure." The registered manager told us they were now checking records daily to ensure they accurately reflected the care people had received.

Staff had regular team meetings to discuss how things could be improved at the home. Minutes of recent meetings showed that any issues with staff practice were addressed at these meetings. A recent meeting record showed staff had discussed the needs of people in their care and were reminded to complete paperwork in people's care records.

At our inspection in May 2016 we identified that managers and staff did not always feel fully supported by the provider. At this inspection the registered manager told us the provider was supportive of them and offered them guidance in their role. Staff told us the provider regularly visited the home and they felt they could approach them if they had any issues. One staff member told us, "[The provider] is here every Thursday. She is very approachable." Another told us, "She comes in weekly, twice a week sometimes. She is always willing to listen. If I thought I couldn't discuss something with [registered manager], the provider is the first person I would phone."

Relatives we spoke with were confident the care provided at Field View was safe, effective and responsive. People knew who the manager was, and told us they were approachable and visible in the home. One relative told us, "We were so happy with the care our relative receives here; when another relative became ill we had no hesitation in placing them here as well." Another told us, "They (managers) are very caring and if you want to speak to them about anything, they are always there."

The provider's policies for obtaining feedback from people and visitors included surveys, resident and relatives' meetings and care plan review meetings. Responses to the surveys were mainly positive and where an issue had been identified, action had been taken. For example one relative had asked for more updates

about their family member's care. Action had been taken to ensure this was done.

The provider showed some understanding of their responsibilities as a provider of a regulated service, but more improvements were required. The ratings from our previous inspection were clearly displayed within the home, but some notifications had not been submitted to us as required by the regulations.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Procedures and processes to keep people safe were not always followed or effectively implemented.