National Autistic Society (The)

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Field View is a care home providing accommodation and personal care for up to eight younger adults in a residential setting who have a learning disability and/or autism. The service consists of a main building and two individual bungalows. At the time of our inspection eight people lived at the service and one person received a supported living service in their own home.

People's experience of using this service and what we found
Quality assurance processes were not effective. Audits had not identified some of the areas we found at this inspection. When audits had identified areas, action had not always been taken to rectify the issues.

The service did not employ sufficient staff to give people a consistent staff team, there was a high reliance on agency use which at times impacted people's daily lives. The provider was trying to recruit staff. We have made a recommendation regarding recruitment and rota systems.

Medication records were not always accurate or fully completed. We have made a recommendation regarding medicines.

Some areas of the service were not clean, and some people's bedrooms required attention. Accident and incidents were reviewed by the registered manager but not always fully explored to learn lessons.

Safe recruitment practices were followed, and we received positive feedback regarding the caring nature of staff. Staff felt well supported by the registered manager.

People were supported to have maximum choice and control of their lives and staff supported /did them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led key questions. The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Relatives were happy with the care their relatives received and shared the positive outcomes the service had on people's lives. People told us they chose what they wanted to do and how they wanted to spend their time.

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

Rating at last inspection
The last rating for this service was good (published 12 March 2020)

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to risk management and oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Field View on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Field View

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors carried out this inspection.

Service and service type
Field View is a 'care home'. 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.

This service also provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at their personal care and support. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, senior support workers, support workers and agency workers. We visited one person in their own home.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medication records were not always robust, accurate or complete. For example, some people's medication administration records had gaps in.
- Protocols were not always in place or reviewed to guide staff when to administer as and when required medication.
- We identified one occasion when one person had received this medication without sufficient time between doses.
- Medication errors were reported but they had not always been reviewed by the registered manager and robust action was not always recorded to prevent reoccurrence.

We recommended the provider review their procedures to ensure medicines are managed in line with best practice guidance.

Staffing and recruitment

- There was insufficient staff employed meaning the service heavily relied on agency staff.
- Staff told us, "Staffing is really bad, if it is really short, we can't give people what they need. For example, activities, people have to wait and go at a later time/day, but we try as much as we can. And "It's extremely difficult at the minute, the impact is people maybe not be able to access usual activities or agency not medication trained or new staff which it makes it difficult and puts extra pressure on us."
- Rotas were unclear and were not individualised to people's funded hours. The system used was complicated and did not always ensure core staff were on the rota.

We recommended the provider seek advice from a reputable source on their rota systems and recruitment.

- Agency staff we spoke to during the inspection were integrated in the team and knew people well.
- The registered manager was aware of the issues with recruitment and were trying to employ staff to fill the vacancies.
- Safe recruitment practices were in place and followed to ensure staff were of suitable character.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments were in place. However, some people's risk assessments had not always been reviewed or updated following incidents. For example, one person had multiple incidents of holding people around the neck but there was no clear guidance for staff to follow in the event of this.

● The registered manager was in the process of reviewing people's care files to ensure they were accurate and up to date.
● Accident and incidents were signed off by the registered manager, although action had been taken at the time of the incident there was not always records of what action had been taken or evidence of learning from incidents.
● The provider did lessons learnt supervisions following serious incidents that occurred in the providers other locations.

Preventing and controlling infection
● The service was not always clean and tidy. For example, the medication room required cleaning and the cleaning rota had not been completed for this room since March 2021.
● Improvements were needed to the environment, such as flooring and carpets requiring attention and a sofa that could not be effectively cleaned. The registered manager started to address this during the inspection.
● Staff had sufficient stock of Personal Protective Equipment. We observed three staff not wearing their face masks in line with guidance. We raised this with the registered manager who addressed this immediately.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of safeguarding procedures and felt confident to report any concerns should they arise.
● People's relatives felt their relatives were safe. One relative told us, "Yes I definitely do think [Name] is safe, they are much happier since living at Field View."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems were not effective at identifying or addressing areas we found at this inspection. For example, the concerns in relation to medication and the environment.
- When audits did identify issues prompt action was not always taken. For example, an infection control audit identified that a sofa had defects so could not be effectively cleaned, however no action was taken, and this continued to be identified for a number of months.
- Accident, incidents and medication errors were not always fully reviewed and there was no robust recording of action taken and opportunity for learning opportunities.
- Records were not always accurate and up to date. Files were not organised and made it difficult to find information, out of date information was often in files.
- Risk assessments had not always been reviewed and updated to ensure accurate records were in place.

Failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider developed an action plan during the inspection to start addressing some of the concerns we had identified.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Records of people's achievements were not always up to date. Health professionals felt further work was required to support people to meet their goals and ambitions.
- Relatives were positive about the care their relatives received. Feedback included [Name] is much happier since moving to Field View, for me it is a relief [Name] living there."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Satisfaction surveys had been carried out to gather feedback from people and their relatives.
- Staff told us they felt supported in their role. One staff member told us, "Yes the management team are really good, the registered manager is really good, they have supported me both in my work and personal life."

● Health professionals felt the service was reactive to feedback given but that the service needed to be more proactive.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was open and honest throughout the inspection.

● The registered manager understood the duty of candour. One relative told us, "They always ring me up if something goes wrong."

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 Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality of the service and maintain complete and contemporaneous records. 17(2)(a)(b)(c)