

Lifeways Community Care Limited

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

Summary of findings

Overall summary

About the service

Farmfield view is a care home providing care and accommodation for people with Autism and learning difficulties providing personal and nursing care. The service can support up to seven people and at the time of our inspection seven people were using the service.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. However people using the service did not always receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

People who lived at the service were not always safe as safeguarding concerns had not been properly monitored or reported in a timely way. This had resulted in a lack of learning from events.

The risks to people's safety were assessed but, did not always fully reflect the needs of the person. People were not consistently supported by enough staff to meet their needs and as a result there was a lack of personalised care. They were not able to undertake meaningful and individualised social activities of their choice.

Staff had not always received up to date training to support them in their roles. People's health needs were not always effectively managed, and although majority of people's nutritional needs were supported, one person's weight loss had not been clearly managed. The environment people lived in was not always well maintained.

People were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service didn't consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; there was a lack of choice and control. People had not been supported to undertake social activities of their choice on a regular basis.

There was a lack of evidence to show how complaints and concerns had been managed at the service. The

quality monitoring processes had not been undertaken consistently to provide effective oversight of the service.

People's medicines were stored and administered safely, and people were protected from the risk of infection. Staff supporting people were kind and caring, they worked to maintain their privacy and dignity.

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 1 March 2019).

Why we inspected

The inspection was prompted in part due to concerns received about staffing levels, safeguarding issues and management of the service. A decision was made for us to inspect and examine those risks.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Details are in our well led findings below.

Requires Improvement ●

Farm 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.

Inspection team

The inspection was carried out by an inspector, and an assistant inspector.

Service and service type

Farmfield View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission in post at the time of the inspection. Both a registered manager 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. This information helps support our inspections and we used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

We spoke with three people who used the service, and prior to the inspection, one relative about their experience of the care provided. We spoke with eight members of staff including the regional manager, area manager, quality compliance manager, acting manager, acting service manager, senior care worker and care workers.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We also looked at a number of agency staff profiles. We viewed a variety of records relating to the management of the service, including quality audits.

After the inspection

We contacted the provider to ask for further records to support our report. However, at the time of writing the report some information requested had not been received.

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 as Good. At this inspection this key question has now 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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always protected from harm, as safeguarding incidents had not always been well managed. Whilst we saw the risks to people's safety had been assessed and clearly documented, staff did not always use the assessments to ensure they safely supported people in their care.
- For example one incident had involved two people who lived at the service. Both people had been assessed as requiring one to one care, but had been left unattended by staff who were meant to be supporting them. This had resulted in an incident where one person had been physically harmed. There was no evidence to show an investigation had been undertaken to, establish why these two people had both been left unattended or, provide guidance for staff to reduce the risk of reoccurrence of this type of incident.
- There were a number of incidents that required reporting to the safeguarding team when they had occurred, but this had not been done. The senior management team were now aware of the concerns and were working to address the issues. However, this lack of clear management and reporting of incidents meant there had been a lack of investigations into incidents and accidents, and resulted in a lack of learning from events.

The lack of management of safeguarding issues was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Some information in individual's risk assessments did not always fully reflect the needs of the person. One person's financial risk assessment stated they had full financial awareness but did not reflect support required from their relative to manage their finances. This information was noted in another part of their care plan.
- Whilst there were personal emergency evacuation profiles (PEEP) in place for people, the information was generic. The PEEPs did not give specific guidance on each individual's needs or based on their assessment of their care needs, how they were likely to behave.
- However the information in some risk assessments provided clear guidance for staff when supporting people. Such as management of health conditions and explanation of behavioural triggers.

Staffing and recruitment

- People were not always supported by appropriate numbers of staff. The majority of people in the service were funded for one to one support throughout the day. We looked at duty rosters and allocation sheets

which showed there were times when the numbers of staff did not meet the required numbers to ensure one to one care was provided.

- During September 2019 the allocation sheet showed one member of staff was required to support two people throughout the day. On each day one person was required to have one to one support for fourteen hours and the other person was required one to one support for seven hours, to support them with their activities. This had impacted on staff's ability to provide the level of care these people required, to safely support them in the community.
- On the second day of our inspection, the allocation sheet showed both the acting service manager and team leader for the service were meant to be supporting people who required one to one care. During the shift the team leader was required to leave the service to support staff in another service to administer medicines three times throughout the day. This meant they were away from the service approximately one and a half hours throughout the day.
- The team leader was also required to oversee the financial budgets for a number of people who were going out of the service into the community. This necessitated them checking monies out and receipts back in with staff. The acting service manager was also required to attend a meeting away from the service during their shift. This meant people did not receive the level of care they had been assessed as requiring.

This lack of appropriate staffing shows the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014

- Safe recruitment practice had not always been followed at the service. One staff record showed a lack of any references for the member of staff. Where the service had been notified about historical issues with a member of agency staff supplied to them, they had not undertaken their own risk assessment to assure themselves the person was safe to work with vulnerable adults.

Using medicines safely

- While there were safe systems and processes in place to order, store and administer people's medicines there was a lack of oversight by managers to monitor staff practice.
- Staff had received training in safe handling of medicines before they were able to administer medicines. However, there was a lack of competency assessment to show staff practices were being monitored. The team leaders undertook weekly audits of people's medicines and there were audit tools in place for service managers to complete, but these had not been completed by senior managers.

Preventing and controlling infection

- People were protected from the risks of infection as staff had training in reducing the risks of infection.
- There was personal protective equipment available for staff to use when supporting people with personal care and undertaking cleaning duties at the service which we saw being used.
- There were schedules in place to ensure communal areas were regularly cleaned, however, there was a lack of evidence to show how people's own bedrooms were regularly cleaned.

Is the service effective?

Our findings

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

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed when they were admitted to the service, however, the assessments were not always followed by staff to ensure safe care was provided. Some people were assessed to require one to one care which was not always provided.
- However, people's protected characteristics under the Equality Act were considered. For example, people who needed support around communication had assessments in place to ensure their needs were supported.

Staff support: induction, training, skills and experience

- People were supported by staff who didn't always have up to date training for their roles.
- While staff told us they had received training for their role and the staff we saw worked confidently with the people they supported. The training matrix we viewed showed a number of staff required updates in relation to their training for various aspects of their roles.
- The training agency staff working at the service received was recorded in their profiles, however, the information lacked detail on when their training modules had taken place.
- Staff told us they received regular supervision however although we asked for evidence to show the ongoing supervision of staff we had not received it at the time of writing this report.

Supporting people to eat and drink enough to maintain a balanced diet

- The majority of people's nutritional needs were met. However, one person's care record showed they had lost one stone in weight in the space of six months. Staff told us this was a result of the person becoming more active. There was a lack of information in their care plan to show how their diet was being monitored to ensure they retained a healthy weight. We discussed this with the acting manager who told us they would address this.
- There was information in other people's care plans to show how staff should support their nutritional needs. This included assessing people's risk of choking and providing staff with information on how to reduce the risks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's health needs were not always effectively managed. A number of people required yearly health assessments but their records showed these had not always been undertaken. One person required a yearly optician assessment, a member of staff told us they thought this had been undertaken, but we could find no evidence on the appointment being made or attended.

- There was also a lack of evidence to show people's oral health was being maintained.
- People did have hospital information profiles in place containing information on their specific needs. This was for health professionals who may support them should they require hospital treatment.

Adapting service, design, decoration to meet people's needs

- The environment people lived in was not always well maintained.
- Throughout our inspection one toilet at the service had a hand written 'out of order' sign on the door. Staff were not able to tell us when this toilet would be repaired.
- The outside areas of the service had rubbish on the floor, and while there was spacious grassed areas there was a lack of security. This meant people could access the busy road at the bottom of the drive.
- People were able to personalise their own bedrooms that reflected their interests and hobbies.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met. We found the service was not always working within the principles of the MCA

- Everyone at the service required a DoLS and where people required reassessments, we were unable to find evidence to show the requests for these assessments had been undertaken. The acting manager told us the previous registered manager had made these requests but they did not have access to their emails to confirm this and there was no evidence in people's records.
- However people's mental capacity had been assessed and where people had been assessed as lacking capacity to make certain decisions, best interest decisions had been made and recorded. People's family and health professionals involved with their care had been consulted.
- Staff we spoke with were clear about supporting people in the least restrictive way. One member of staff said, "They [people they supported] have the choice to make an unwise decision." but the member of staff went on to say they could prompt or make suggestions to people to help them with choices.

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with respect by the staff who supported them. During the inspection we saw positive interactions between staff and the people they supported.
- A relative we spoke with told us, although they were aware there was a number of agency staff supporting people they were happy their relative was supported by a regular group of staff who knew their needs well.
- People we spoke with told us they enjoyed living at the service and liked the staff who supported them.
- Staff told us they enjoyed working at the service and worked to support people in the way they had chosen to be supported. One member of staff said, "It is not like coming to a job. You are coming into someone's home."

Supporting people to express their views and be involved in making decisions about their care.

- People's communication care plans showed how to support people express their views. For example, one person's care plan showed the words they would use in sign language to show what they wanted. There was also information on how best to communicate with the person, by using simple language. During our inspection we saw staff following this guidance to help the person express their views on their day to day care.
- Although no one at the service required the service of an advocate we saw information on advocacy services available for people in easy read formats.

Respecting and promoting people's privacy, dignity and independence

- The majority of time people's privacy and dignity was maintained. However, on one occasion, the bathroom door was left unlocked when a person was managing their personal care, with no signage on the door to show the bathroom was in use.
- People told us they were happy with the way staff supported them and spoke with them. We saw a number of interactions to show people were treated with respect and staff worked to maintain their independence. One person offered to make us a cup of tea during the inspection and they were supported to do so.
- When people wanted to spend time alone in their rooms staff respected this, and when one person was going out they asked staff to lock their room for them which staff did.

Is the service responsive?

Our findings

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

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 people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Although there was information in people's care plans to show how staff should provide personalised care, people did not always receive this.
- People were not always supported to be involved with the different activities they had chosen and had previously enjoyed.
- There was clear documentation to show one person enjoyed going out on public transport for rides into the local town. Daily records showed the person had not been supported to go out for these trips for long periods of time. Throughout August and September the person spent the majority of their time in the service with an occasional walk to the local shop.
- Another person was meant to be supported on a one to one basis when they went out. The daily allocation sheet showed the person often shared their support with another person who was also meant to receive one to one care. This meant neither person could be supported to undertake activities of their choice. The person's care records showed they enjoyed undertaking jigsaws, colouring and playing with building bricks. There was no evidence in the daily records that staff had supported the person to undertake these activities and we saw no evidence of this during our inspection.

This meant people did not received person centred care, this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2019

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The staff at the service worked to ensure people's communication needs were met. Where there were barriers to communication we saw arrangements in place to overcome those barriers. For example, people who were hard of hearing had hearing aids in place. Staff understood the different signs people who were non-verbal used to express their needs and there was easy read information to support people understand the information they received.

Improving care quality in response to complaints or concerns

- Although we saw there was an easy read complaint policy in place at the service, there was a lack of evidence to show when concerns and complaints had been received or if they had been managed

effectively.

- Although staff told us they would know how to deal with complaints, the previous registered manager had not kept any records of issues raised in the service, so we were unable to see if issues had been dealt with to people's satisfaction.

End of life care and support

- The information around people's end of life wishes was not clearly documented. One person's care record had a blank template of an end of life wishes document with no indication of whether this had been discussed with the person. Another person's record stated their wishes had been discussed with their family but there was no accompanying information to show what discussion had taken place.

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 Requires Improvement. At this inspection this key question has now remained the same. 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.

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

- There had been a number of changes to the management of the service over the previous months, which had resulted in a lack of leadership at the service. This had affected outcomes for people living at the service.
- Incidents had not been properly monitored and reported to the relevant senior managers and the local safeguarding teams. This had resulted in a lack of learning from events. This meant that the service had not notified the CQC of significant events in a timely way.
- Although staff supporting people had knowledge of their needs, there was not a positive culture to support person centred care. The lack of sufficient staff had resulted in a number of people not able to undertake the regular social activities they enjoyed. This impacted on the quality of life for these people.

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

- The lack of clear leadership at the service had a negative effect on the quality of care people at the service received. Whilst the provider had brought in a senior management team to support staff at the service, this team had changed a number of times resulting in a lack of continuity and consistent oversight of the service.
- There was no registered manager or service manager in post. The senior management team had appointed an acting service manager who had only been in their post two weeks. In the last year the service had three different regional managers in post. Our discussions with the local authority showed there were issues they had raised with the provider on a number of occasions and improvements made had not been sustained.
- The lack of oversight of safeguarding incidents meant there had been a lack of learning from events.
- Quality monitoring processes had not been undertaken in a meaningful or consistent way. We saw senior carers had consistently signed to say documentation on people's care had been completed, or maintenance checks at the service had been undertaken. When we checked we found the documentation was incomplete and checks had not been carried out. These issues had not been identified by the senior managers at the service.

- The provider had quality monitoring processes in place which required the registered manager or service manager to complete a comprehensive audit of safeguarding, medicines, incidents and accidents at the service, which had not been completed for the previous two months.

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

- People and staff were not always involved in the running of the service. There was a lack of staff meetings to keep staff informed of the changes over the previous months at the service. We saw the last staff meeting had been in January 2019. One relative we spoke with told us they had asked about the leadership of the service but had not been given a clear understanding of what was happening in terms of the management team.
- Staff told us they received regular supervision, however, we asked for evidence to show the ongoing supervision of staff and had not received it at the time of writing this report.

Although we saw the present management team were working to make improvements to the service, the lack of consistent leadership had impacted on the quality of care people at the service received and has resulted in a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 9 HSCA RA Regulations 2014 Person-centred care People were not supported to undertake person-centred activities
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding issues had not always been recorded and reported to relevant safeguarding teams
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance there was a lack of consistent oversight of the service