Field View Residential Home

Field View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 3 May and 4 May 2016. The visit was unannounced on 3 May 2016 and we informed the registered manager we would return on 4 May 2016.

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 14 people living at the home, however one person was in hospital.

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 2015, we rated the home as requires improvement. At this inspection we looked to see if the provider had responded to make the required improvements. Whilst we found some areas of improvement had been made, we found additional areas of concern that had potential to place people at risk of harm.

There was a lack of management oversight by the provider to check delegated duties had been carried out effectively. The quality monitoring systems included reviews of people's care plans, health and safety checks and checks on medicines management. These checks and systems were not regularly reviewed and completed so it was difficult for the provider to be confident people received a quality of service they deserved. Accidents, incidents and falls were not regularly analysed to prevent further incidents from happening. Improvements were required in assessing risks to people and how staffing levels were determined to ensure safe levels of care were maintained to a standard that supported people's health and welfare.

We checked the registration status of the provider and found the partnership was no longer active as a partnership because there was only one partner remaining. This suggested the remaining partner was carrying on without the appropriate registration. Where we refer to the 'provider' in the report we do so within this context.

Health and safety checks were not always completed to ensure risks to people's safety were minimised. We identified some health and safety issues to the registered manager and the provider on the day of our inspection where we had immediate concerns to people's safety.

Risks to people's health and welfare were identified but not effectively managed and where people were at risk of harm, actions had not been taken to keep people safe. Care plans provided information for staff that identified people's support needs and associated risks. However, some care plans and risk assessments required information to be updated to ensure staff provided consistent support that met people's changing

needs.

There were not enough staff on duty to respond to people's health needs and to keep people safe and protected from risk. The registered manager completed a dependency tool to establish safe staffing levels but there was no effective formula that calculated what those safe staffing levels should be. The registered manager and deputy manager regularly supported staff on shift which meant some quality checks and improvement actions were not always identified and resolved. This affected the quality of service people received.

At the last inspection we found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At this inspection there were some improvements in how people's capacity was determined, but further improvements were still required. Mental capacity assessments were completed but these were not always decision specific and records of those involved were not always completed. Five people had a DoLS in place at the time of our inspection. The registered manager acknowledged people's care plans around mental capacity required improving.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at Field View and a relative agreed their family members felt safe and protected from abuse or poor practice.

People felt cared for by staff who had the skills and experience to care for them. Staff understood people's needs and abilities and received updated information at shift handovers. Staff training was completed, but not all staff had received training to update their skills in line with the provider's expectations. There was no effective system to identify which staff required training updates.

People were offered meals that were suitable for their individual dietary needs and preferences. People were supported to eat and drink according to their needs, which minimised risks of malnutrition but there was limited interaction and conversation with those staff who supported them. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health.

People said staff provided the care they needed. Care plans were reviewed although some information required updating to ensure staff had the necessary information to support people as their needs changed. Some people felt their physical and mental stimulation was limited because they were not proactively supported to pursue their own hobbies and interests.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider's registration status was no longer valid and asked the provider to take immediate action to ensure this service was registered in accordance with the Regulations. 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?

Inadequate

The service was not safe.

Staff supported people who had been identified as being at risk although risk assessments were not always updated to reflect people's current health needs. Where people were identified at risk of harm, measures were not taken to keep people safe. Staff understood their responsibility to report any observed or suspected abuse and medicines were administered, recorded and stored safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had completed essential training to meet people's needs but this was not always updated in line with the provider's expectations. Where there was conflicting information about people's capacity to make specific decisions, mental capacity assessments had not always been completed. People were supported to maintain their health and referred to external healthcare professionals when a need was identified, but some people identified at risk, had not always received the support they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff provided care in a kind and sensitive manner, however there were periods of time when staff were not available or attentive to people's needs. People told us when staff spent time with them, staff were patient, caring and understanding.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their families were not always involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time but there was minimal physical and mental

stimulation for people, which did not always meet their needs.
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Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some systems required better organisation to ensure improvements that had been identified, resulted in positive actions being taken. The provider's risk assessments of the premises had not identified potential risks to people and regular maintenance checks were not effective. This meant that a number of shortfalls continued in relation to the service people received. People and staff felt supported by the registered manager, but staff felt the provider was not always proactive to resolve concerns.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 May 2016 by two inspectors which was unannounced. We told the registered manager we would return on 4 May 2016. On day two, one inspector visited the home.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Field View. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

The provider is required to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made, so the provider did not have an opportunity to complete this. During this inspection, we asked the registered manager and provider to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our last visit.

Many of the people living 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 assess whether people's needs were appropriately met and identify if they 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.

To gain people's experiences of living at Field View, we spoke with three people and one relative. We also spoke with the provider who was the owner of the home, registered manager, deputy manager, three care staff, a maintenance person and the cook. We also spoke with two visiting community nurses.

We looked at four people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Inadequate

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 ability to communicate. One visiting relative told us their family member moved to the home because it was unsafe for their relative to continue living in their own home. This relative told us since moving into Field View, their family member continued falling. They told us, "[Person] has fallen three times since they have been here, [person] is unsteady on their feet." They explained staff always told them what had happened. They said, "The falls are at night, they have a frame but they forget to use it." We asked if any further support had been sought to establish why their relation was falling. They told us they did not think so.

Some people we spoke with told us they were at risk of falling, and had fallen whilst at the home. Staff told us some people had alarm mats on their bedroom floor, but sometimes they did not always alert staff, depending where they fell. Comments people made to us were, "I have had falls in the room [bedroom] mainly because of the stroke affecting my legs, and sometimes the medication affects me too. If I fall on the floor away from the alarm I have to knock on the floor to get attention" and "I have fallen 3 times in the last 6 months, I get giddy and can't get up, I have to use the alarm or bang the floor."

Risk assessments for walking aids and tripod walking frames had been completed and reviewed for people at risk of falling. These risk assessments provide staff with information and guidance to support people safely, when transferring. During the first day of our inspection we saw a number of walking frames against the lounge wall, but did not see many people use them. In some cases we saw staff supported most people to walk around the home, holding out their arm for support. One staff member said this approach was taken some times because it was quicker and enabled them to support others more quickly. During the second day of our visit, we saw staff supported people to use their walking frames to move and to mobilise safely

Prior to this visit, the provider had notified us about serious injuries, some as a result of people falling. We looked into some of these incidents during our inspection. We were concerned the registered manager had not taken positive action to see why people who were identified at risk of falls, were falling, and what interventions could be taken, to minimise the risk of further falls and potential injuries.

For example, we looked at one care record for a person who was identified at risk of falling. Between the periods of 22 October 2015 – 3 March 2016, this person had fallen 20 times. Falls risk assessments were completed which identified this person was at high risk of falls. These assessments had been reviewed in January 2016, February 2016 and March 2016, stating 'no change to assessment'. Falls were recorded but there was no evidence of action that had been taken to minimise further risk of falling. Staff knew this person was at risk of falling and said they always kept this person observed to reduce the risk, although on occasions this was not always possible when they had to support other people.

We looked at two further separate incidents in February 2016 where the provider notified us two people had fallen, which resulted in both people sustaining 'back fractures'. One person had fallen out of bed onto the floor. We asked the registered manager what action they had taken to prevent this from happening again,

such as considering a hi low bed or bed rails. The registered manager said, "Nothing." The second example happened two days later which involved another person who was being assisted to bed by a staff member. When they sat on the edge of their bed, they were not far enough onto the bed, slipped and fell. The registered manager told us, "Staff did not position them correctly, they fell." We asked what preventive measures had been taken to reduce this from happening again. We were told an alarm mat was in place and staff made sure this person was in the middle of their bed. However, this person had not been referred or assessed for bed rails or alternative beds to reduce the potential of further falls from bed. Furthermore, those staff involved had not been observed, reassessed or retrained to ensure their moving and handling practice remained effective to keep people safe.

We asked the registered manager if they reviewed and analysed incidents and accidents within the home. They told us they had not completed a falls analysis since January 2016. We asked, following the fall in February 2016 where one person had a back fracture, if they had checked to see what caused it, and if it could be prevented from happening again to this person or others. They told us they had not. Subsequently two days later, another person sustained a back fracture falling from their bed. They told us they completed accident forms but had not made any referrals to the GP or the falls teams. They gave us a reason, saying, "I am helping out on the floor, usually twice a week. The management stuff is left and gets behind." Speaking with the provider on the second day of our inspection, they were not aware management checks were not up to date.

At the beginning of our visit, the registered manager walked both inspectors around the home. They told us they walked the home on a daily basis to make sure any risks or maintenance issues were identified so any potential risks to people could be minimised. Walking around the home, we found some health and safety issues that could have potential to cause serious injury. We checked examples of first floor windows, and found some people's rooms had access to a flat roof. None of the windows in the four rooms we checked, had restrictors to prevent windows opening wide enough for people to get through. We found one person collected stones from the garden and they threw these out onto the sloping roof, above the main entrance. This person was living with dementia and had some cognitive impairment. We saw evidence that stones and pieces of broken roof tiles had fallen onto the ground below. We spoke with this person and they told us they kept them on the roof, then when needed, "I would open the window and reach out and get them." On separate days, individually we took the registered manager and provider outside to the front of the property to show them the amount of stones on the roof. Neither were aware of this or had knowledge of the possible risk to the person or to people leaving or entering the building.

On the ground floor corridor we saw a wall light that had the glass front removed, exposing electrical wiring and the metal light frame. The light worked and was in use. Because this was a wall light, it was within reach for people to touch. This posed a risk for people who were unaware of risks to their personal safety due to their cognitive impairment. We asked the registered manager how long the light had been in this condition. They told us, "I have not noticed before, so I don't know." We asked the maintenance person if they had seen this or been told to repair it. They said they had not noticed the light, nor had they been told to repair it. We asked for this to be repaired and this was made safe by the end of our first day.

We spoke with the maintenance person who visited the home twice weekly to carry out necessary checks and routine maintenance. They told us they checked water temperatures weekly. We checked examples and found temperature checks were recorded in a downstairs bathroom for the bath and hand basin that exceeded safe water temperature levels. This bathroom was in use. They told us because staff supported people and the bathroom door was bolted (not locked) it was okay, however we could not be sure people did not access this bathroom on their own and be at risk of scalds. We also checked the sluice room on the first floor and found it contained cleaning equipment and chemicals. A sign on the door said it was to be

kept locked at all times. This door was not locked and was only secured by a bolt. For people living with dementia, this posed a risk to their health and wellbeing as they could access this room. We asked the registered manager about the water checks and they could not explain to us why action had not been taken to resolve this. When asked about the store cupboard containing chemicals, they said, "Until you pointed it out I didn't realise."

This was a breach of Regulation 12 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff and asked them whether people were protected from risk and if they did all they could to keep people safe. Staff told us it was not always possible to observe people throughout the day, especially if some people needed assistance from two care staff. Staff said two care staff helped some people transfer which meant they were mobilised safely. However staff recognised this left people who were vulnerable to falling, because there was 'no eyes and ears' on the floor. Staff and records confirmed, a number of falls people had were unwitnessed. Staff told us some people used walking aids, such as frames or tripod frames which had been recorded in people's risk assessments, but they told us they did not always support people to use them because of time constraints in supporting everyone in the home.

Staff said at certain times of the day, such as mornings they were busy and it was difficult to spend time chatting with people, and observing people to ensure they remained safe. Some staff told us they provided 'task based' care because they went from supporting one person to another, or helping another staff member where someone required two care staff.

The deputy manager completed staff rotas. The deputy manager told us staffing levels each day to support 14 people were three care staff in the mornings, reducing to two care staff in the afternoons and at night. A cook and housekeeper were also included and the care team was supported by the deputy manager and registered manager. We asked them and the registered manager how they calculated staffing levels to ensure it met people's needs. The registered manager told us they used a dependency tool which assessed people as high risk, medium risk, low risk. We asked how this information calculated the number of hours required. The registered manager told us, "We know people, it's what we have always staffed to." The registered manager or deputy manager could not say for certain, staffing levels reflected people's needs. Risk assessments and care plans were not always reviewed so it was difficult to be sure staffing levels reflected people's changing needs.

Our observations throughout the inspection, showed staffing levels were not sufficient and the high number of incidents and accidents showed this impacted on the safe care people received. For example, on the first day of our visit we saw periods of time where people were left unobserved in communal areas of the home for at least 20 minutes. Other people spent time in their rooms, and one person spent time walking around the garden area. People living at the home were identified at a high risk of falling. Incidents and accidents showed people had fallen throughout the day and night, some recorded as unwitnessed. The registered manager told us they provided a lot of support to the staff, and the deputy manager also helped out. The registered manager told us staffing levels at times impacted on them directly, which prevented them completing timely management checks, falls analysis and to oversee the home to the quality they wanted. They said, "I do help out, it affects the management. I just have to do longer hours." We asked if they could get additional staff to help keep people safe. They said, "I have a budget. " The lack of staff to support people impacted on the quality of care people received and had potential to place people at risk of avoidable harm.

We were concerned that staff levels and the dependency needs of the people impacted on the levels of care

and support people received. Staff did not always have the time to support people in a way they needed to help keep them safe and protected from risks.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

All staff had a clear understanding of the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home. One staff member said, "I would not stand for anything like that. I would report it to [Registered manager] and CQC." This staff member said they would also report any concerns to the owners and felt confident to whistle blow. All of the staff we spoke with said they had not seen anything that required reporting or gave them cause for concern.

The registered manager said the provider had a policy and procedure about safeguarding and this linked with the local authority's protection of adult's procedure. The registered manager told us what action they would take if they suspected abuse. They told us they would refer any incidents of abuse to the provider, CQC and the local authority.

Medicines were delivered from the pharmacy in colour coded blister packs, which were marked with the name of the person, and the time of day they should be administered and kept with a photo of the person to confirm their identity. Medicines delivered in boxes and liquid form, were kept in a locked cupboard in people's rooms, unless they required cold storage where they were kept in a medicine fridge. Liquid medicines were marked with the date the medicine was first opened, to ensure medicines were administered or disposed of within their expiry date.

The medicines administration records (MAR) we looked at, were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Staff recorded when medicines were not administered and the reason why not. For example, if a person declined to take them. When creams were prescribed, body maps were included so staff knew where cream was to be applied, however not all creams recorded an open date which could mean the cream may not be as effective if used after the recommended 'use by' date.

Staff received guidance to ensure people's medicines were administered appropriately and staff administering medicines told us the registered manager carried out observations of their practice to ensure they continued to administer medicines safely.

Requires Improvement

Is the service effective?

Our findings

A relative told us they believed their family member received care and support from staff who knew their family member well, and who had the skills and experience to care for them. One relative said, "Staff are very good, approachable and not a problem at all."

Staff and management gave us mixed views about the quality and access to training. For example one person said they received an induction before they started working at the home which they found helpful, but had not had much training since. They told us, "I undertook training before I started, but I can only recall training in manual handling training and dementia training. I have not had any other training since I started work." Other staff said they felt they had the training they needed to provide care to people they supported. The staff team consisted of new and experienced staff. One staff member said they had just started an NVQ level 3 in care and another staff member had worked in care for over 10 years. They told us, "I have good knowledge of mental capacity, deprivation of liberty safeguards, then was constantly training on manual handling, fire, dementia awareness, food hygiene and confidentiality.

The registered manager used a training schedule to make sure staff received training updates when required, however this showed not all staff had received this. At the inspection we were given a training schedule that was incomplete. We asked for an updated copy to be sent to us after the inspection. The revised training planner sent to us still included staff whose training had not been refreshed, in line with the provider's expected timescales. We were told future training was planned for safeguarding adults and moving and handling training. The registered manager told us they found it difficult accessing training courses, and had some concerns around dementia training because, "Unless courses are free, it is hard to access." They said if there were no free courses, it was the responsibility of the provider to source and pay for courses. The registered manager said they needed support from the provider to make sure staff received this training and they would inform them if they needed help booking certain training courses.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

Mental capacity assessments were not always accurately documented for people who lacked capacity to make certain decisions. It was difficult to establish whether people, their family and appropriate healthcare professionals were involved because the records were inconsistently completed. We found where people lacked capacity, the information was not always decision specific which meant staff may not provide a consistent approach when supporting people with their decisions. The registered manager said they had made improvements following our last visit and they were much clearer now about what they needed to do to ensure they supported people effectively in line with the MCA.

Records of best interest meetings and any decisions had not been recorded. It is a requirement to record best interest meetings and mental capacity assessments. The registered manager confirmed families were involved but was unable to support this with records of those meetings and decisions. From training records and speaking with a small number of staff, we could not be sure all staff had received mental capacity training. We found staff knowledge and understanding of mental capacity and what it meant for people, varied. However they followed the principles of the Act when providing people with support and respected the right of people with capacity to make decisions about their care and treatment. Where people lacked capacity, staff encouraged everyone to make choices. Some people we spoke with told us staff recognised they wanted to remain independent, which included making their own day to day decisions. Staff gave examples of how they sought consent and how they made sure people had consented before any care was provided. One staff member said, "If [Persons name] doesn't want to do something for example eat, we should still offer fluid and food because of the importance." Another staff member said, "People lack ability to speak or make decisions for themselves…. for example [Persons name], I ask her what clothes she wants to wear, she will point and I will get what she wants."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, four applications had been approved by the local authority to make sure people's freedoms were not unnecessarily restricted. The registered manager said additional DoLS applications for people had been made and were awaiting decisions to see if further authorisations were approved.

We observed the support people received during their lunchtime meal. We felt there was an overall lack of effective management to ensure everyone had the same level of service and experience. For example, some people were offered a drink of orange, whilst others were given a choice. People appeared to be having the same meal and staff took meals from the dining area to people in their rooms, before one person in the dining room had been served. This meant when some people sat together, some ate their desserts when others had just been given their main course. The person was not upset that other people at their table had been served but the carers did not speak with them to explain the reason for delay.

The registered manager wanted staff to sit and eat their meals with people, and also for staff to sit with people who needed assistance. On the first day of our visit some staff sat with people to eat their meal, but we saw little or no conversation took place. We raised this with the registered manager who said they wanted staff to sit and talk with people, and they had previously seen staff do this, although this was not our experience. Music was played at a level that made it difficult to have a conversation and we did not see people being asked, what choice or style of music they preferred. Staff spoken with confirmed people had not been asked.

The cook told us they received information about people's dietary needs so they made sure people received their foods in a way that did not put them at risk. They told us they prepared two choices and if people wanted an alternative, they did what they could to prepare alternative choices. They said they knew people's choices because staff made them aware. We were told on day one of the inspection, prepared choices were toad in the hole, or shepherd's pie.

People and a relative we spoke with were pleased with the quality of food. Comments included, "[Person] had a bit of a food phobia, but she now eats well and enjoys food. She is given choice of two meals and will always have two puddings, staff know this and are prepared", "Food is very good," and "The food is not bad and they give you enough. I like boiled ham which is on the menu. You normally get a choice of two meals to choose from."

We saw people were offered a variety of drinks during our inspection visit and staff understood the importance of keeping people hydrated. Staff told us they checked people remained hydrated and nourished. Staff said where people were identified as being at risk, people were weighed weekly and if their weight caused concern, support from dieticians or other health professionals was requested.

People told us they saw other healthcare professionals when required such as a GP and a chiropodist. On day one of our visit we spoke with two visiting community nurses. They were complimentary about the staff team and the support people received. They had confidence staff followed advice and guidance. They said, "Staff discuss equipment and waterlow scores, they check equipment and check air mattress. I have confidence staff will make contact with the appropriate people, they [staff] should get G.P involved when weight loss becomes too much." They also said, "Weights are done every month, staff are aware to contact the dietician. We rely on weights taken by carers, if we do not see a weight we will ask staff. Weight charts are generally up to date."

Requires Improvement

Is the service caring?

Our findings

A relative told us they believed their family member was well cared for by staff. They said they thought they were well cared for because staff knew their family member well and had encouraged them to eat. One relative said, "[Person] is always clean, they seem very organised, and they do communicate if there is a problem."

Most people were unable to express their views and opinions so it was difficult to see if they were involved in their care decisions. Some care records were not signed by the individuals but staff told us family members were involved when any care decisions needed to be made. The registered manager said care plans were reflective of people's needs and were reviewed monthly, although some of the care plans required further improvements so staff provided consistent care. They said people were not routinely involved in monthly reviews. They said relatives were always involved and updated when people's health and wellbeing changed. A relative we spoke with confirmed this.

We found there was an inconsistent caring approach by staff in how people were supported. During lunch we saw staff spent time eating their meals with people in the dining area. We did not see staff talk with people and felt this was a missed opportunity for people and staff to exchange conversation. One lady needed assistance to eat their meal. They were brought into the dining area and were visibly upset. The staff member talked with them to reduce any anxieties. We did not see this person being supported to eat but we saw the staff member ate their meal. We were not confident the person had eaten anything at lunchtime so we spoke with the staff member. They did not explain why the person had refused their meal but assured us this person could have something at three o'clock or at five o'clock if they wished, before their evening meal.

We found some examples where people's choices were not considered. We asked one person we spoke with if they got support from caring staff who cared for them in the way they preferred. They said, "I don't have a choice about sex of carer, they are all female, but I am not bothered as long as they are kind and considerate." We asked if they were kind and considerate to their needs and they told us, "The staff are alright, not too bad. Some are better than others, the better ones speak to you, are more friendly; the other ones just do their job." The staffing levels had impacted on the time staff had to spend with people.

We saw staff spoke respectfully and explained what they were doing as they supported people to move around the home, or if people were upset or agitated. Staff helped keep people calm and relaxed. For example, one person at lunchtime became upset and anxious when brought to the table. A staff member sat with them, explained where they were and offered words of reassurance. We saw another example where a person knocked over a drink. Staff told the person not to worry, accidents happened and they would clean it up. We also saw a staff member assisted a person to eat lunch, with patience being demonstrated in the time being taken. We spoke with the staff member and they told us they tried to encourage people's independence because they thought people would not do things for themselves if staff always did things for them. This staff member was seen to help guide a person's hand rather than supporting them to eat.

Staff respected people's privacy and dignity and they understood people's need for personal space and privacy. One person said they preferred to spend time in their room because they preferred their own company and staff respected their right to privacy and choice. People's bedrooms were individually furnished with personal items such as furniture, pictures, photographs and other personal memorabilia.

Staff understood the importance of caring for people and they described to us the qualities staff had at Field View. Staff said there was a good team that knew people's needs and they all helped each other. All the staff said they enjoyed working at the home and got on well with people they supported. The registered manager said they had a good team and were confident staff cared for people at the home.

Visiting healthcare professionals were complimentary about the staff team, describing them as a caring team. They said, "I think staff are very caring, always a tea trolley with biscuits (for people). I think they [staff] have personal relationships and deal with people as individuals, they know them all."

Requires Improvement

Is the service responsive?

Our findings

We observed staff interactions with people and found staffing levels at times, meant staff were not always responsive to meet people's needs. We spoke with staff and asked them if they responded to people's needs. Most of the staff said, they needed extra staff because some people were at risk and they were unable to check all the time to make sure people were safe and cared for. One staff member told us a number of people were prone to falling. They said, "Because people are so mobile we can't restrict them, that is why I think three staff are needed so staff can walk and follow someone to make sure they are okay." They said it was difficult to respond immediately to support people because, "It is not always possible to keep an eye on everyone".

During the first day of our visit we spent time in the lounge areas to see how people were supported and whether staff were responsive. We saw people were left unsupervised for periods of time. In one example, four people were in the lounge and we also saw through the window, a person was walking around the garden area. People were sat in chairs and one person occasionally called out, though we could not hear what they said. For 20 minutes there was no staff presence checking people were okay. The person in the garden disappeared out of sight for four minutes, behind the shed. This person could have fallen and staff would not have been on hand to provide support in a timely way.

The layout of the home meant it was difficult for staff to see where people were. Staff said it was okay in the communal areas but the corridors and other floor meant they could not cover all aspects of the home. One person preferred to spend time in their own room and said if they needed help, staff responded. They said, "I spend a lot of time in my room. I can call staff when I want, they come pretty quick." We asked them if they were encouraged to spend time with others, or whether staff helped them pursue their interests. They said, "I don't get involved with activities, other residents don't talk much anyway." This person said staff checked on them but did not always spend time with them.

We saw staff spent some time with people talking about their lives, memories and looking at old photographs. One person spent time painting pictures which they enjoyed. A relative felt there were not many opportunities for people to get involved in activities. They told us there was, "Not many activities, no timetable and no trips out that I am aware of." The registered manager acknowledged the home environment was not specialised enough to be responsive to people living with dementia. The registered manager told us they wanted to improve the quality of interests available to people. They said they wanted to purchase items that could help jog people's memories, such as, "Old photographs, sewing machines, old kitchen equipment. It would help people, staff could talk with people about things." They said, "We are not geared up for dementia. I have tried to get a grant so we can get things."

The provider submitted a provider information return (PIR) to us in May 2015. This included improvements they wanted to make by May 2016. One improvement the provider identified was the use of a sensory bathroom to encourage people with their personal care. The PIR stated 'We would like to redesign our downstairs bathroom into a sensory bathroom, paint the bathroom in warm coloured tones, add decorative features including indoor plants and hang more home like pictures on the walls. Learn what music the

resident finds soothing and play it during bathing, with slow changing lights.' The registered manager told this had not been done and would only be completed through fund raising.

A relative told us they were involved initially in the care planning and felt involved in those care decisions. They said, "I think I have signed the care plan but not spoken about it since. I have been called into the office a few times but [person] gets on with most people at the home."

We asked staff if they read people's care plans and if they knew people's needs. We got mixed responses from staff. Some staff said they did not have the time, although from speaking with staff we found they were aware of people's needs. We found care plans and care records were not always reflective of people's needs. Some daily records did not record key events, such as a fall and care plan audits had not been completed since December 2015. Where people's needs had changed, records did not always record how the provider had responded.

We looked at four care plans and found inconsistent information and not everyone had been involved in how their care was planned. People's care records did not always support their current needs, particularly if they had fallen, or where people's behaviours had changed or if there were new or emerging risks. We found care records were not consistently reviewed. Although staff spoken with could tell us about people's needs, staff did not always have accurate and available information available to refer to if needed. This had potential for inconsistent levels of care to be provided, especially when other healthcare professionals were involved and there was limited information recorded.

The registered manager told us they had received two formal complaints in the last 12 months which had been investigated and resolved. The registered manager said one complaint investigation around protecting people's dignity, led them to discuss this with a staff member to raise and improve their awareness. The provider's complaints policy was located in the communal area. This provided people with timescales and set out how their complaint would be actioned. The registered manager said people usually came to see them to discuss any issues which meant the need to raise a formal complaint was reduced. They said recent feedback from surveys had not identified any concerns or complaints about the service. During our inspection, no one we spoke with had any concerns or complaints.

Following our last visit in May 2015, the registered manager had introduced 'resident and relative' meetings. A relative said, "I am aware of residents meetings, where issues could be raised, there is a notice up," although they had not raised any concerns. They said they would raise their concerns if needed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2015, we found some areas that the registered manager and provider needed to improve, however they were not serious enough to have breached the Health and Social Care Regulations. There was a commitment expected from the provider that improvements would be made and as a result, people received a good standard of care. At this visit we asked the registered manager their thoughts about the last visit in May 2015 and if they had found it beneficial. They said, "I was disappointed in myself. I was annoyed. We have tried our hardest. The provider needs a good inspection, all we can do is learn." We saw the provider displayed their inspection rating from our last visit which is a legal requirement of the regulations.

Prior to this inspection we looked at the registration status of the provider and followed this up at this visit. 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 providers' current registration status with us was not correct. We told the provider they must notify the local authorities and commissioners of services they contracted with in case this had any impact on existing contracts which may affect the service people received. Following our visit, the provider confirmed they had done this. They told us they had sought professional advice regarding the registering of a new legal entity and they said they had started the application process with us to register the service in accordance with the registration regulations appropriately.

This is a breach of Regulation 21 Care Quality Commission (Registration) Regulations 2009.

At this inspection we found areas that we previously identified as required improvement had not been sufficiently addressed. We also identified other areas of concern, such as people at risk of falls with no intervention measures, ineffective health and safety checks and staffing levels that did not support people's changing needs. We found the provider's audit processes to monitor the quality of the service provided were ineffective and insufficient to ensure people received safe levels of care. We found a number of examples during the two inspection days which had not been identified by the registered manager or the provider from their own audit processes.

For example, we found three people living at the home were identified at high risk of falling. One person had fallen 20 times from 22 October 2015 to 3 March 2016 and had suffered a serious injury. We looked at their care plan in detail and spoke with staff and the registered manager about how they supported this person. Whilst individual accidents and incidents were recorded by staff and a monthly total for the home, we found no overall analysis of accidents took place. We found when people had falls, a review of their falls risk assessment had not taken place to consider whether actions were needed to reduce the risks of reoccurrence of falls. A tripod walking frame risk assessment for January, February and March 2016 recorded 'no change to assessment'. Care plan reviews stated the number of falls, but did not take into account any action or measures to reduce or identify triggers. We looked at one accident form dated 22 January 2016. It recorded a fall that resulted in a skin tear requiring a dressing. The reason for the fall was '[person] walking from lounge to dining room without her walking frame and lost her balance'. The risk assessment stated

'walking without her frame could result in falling which could cause skin tears, muscle strain, fractures.' This person had sustained skin tears and a fracture following falls. The lack of effective monitoring meant that no consideration had been given as to how the overall number of accidents could be reduced, to avoid risk of reoccurrence and to keep people safe.

Speaking with the registered manager and reviewing their systems we identified a lack of proactive management and leadership which affected the quality of service provided. For example, we looked at the processes the registered manager used to make sure people received safe and effective care, from staff who were trained and qualified to provide that care. The system that monitored training had not been updated for some time. We asked for the latest copy, and were provided with a training schedule that showed almost all staff last received manual handling training in April 2011. The registered manager said staff had completed this since 2011, but they were unsure who still required specific training updates in other areas. After the visit, the registered manager sent us an updated copy of the training schedule, however this still showed gaps in staff training, some of which was being planned, for example, safeguarding for vulnerable people.

Health and safety checks were not always effective to ensure people remained protected, and the environment was safe. Staff reported maintenance issues and these were followed up and rectified where required. The maintenance person was responsible for completing water checks and we found some communal bathroom areas recorded water temperatures nine – 10 degrees higher than safe limits. We asked the registered manager and staff about this and they were not aware safe limits were exceeded. First floor windows did not have the required restrictors, which meant windows could be fully open presenting a risk to people. Doors that were required to be kept locked at all times were only secured by a bolt and could not be locked. Wall lights were not always covered, exposing live electrical wiring. The registered manager told us they did a daily walk around but had not identified the concerns we found during our visit. We asked why these issues had not been found and they said, "I wish I could give you a reason why, but I can't." The lack of attention to ensure the environment remained safe for people had potential to place people at unnecessary risk of harm.

From speaking with staff and the management team (registered manager and deputy manager), they felt the home was not supported by the provider as much, as the provider supported their other two homes. The management team and staff said they worked well together and it, "Feels like a family, we all work well." The registered manager said they needed additional help and support because they spent time helping staff on the floor. They said if this was reduced for them and the deputy manager, it would help them complete the management checks. They also said they wanted to increase the quality of dementia care by purchasing items for reminiscence which staff could use when supporting people. They said any additional items were paid for from fund raising but staffing levels did not always allow for this. We asked if they had raised these issues with the provider and we were told they had, however there was no evidence to support this or what was done. We asked if the registered manager got support, or had meetings with managers from the provider's other home managers. They said, "I don't have any, I don't get support."

On the second day of our inspection we spent time with the provider. We highlighted some of the concerns we found and asked them for their views. The provider was surprised improvements had not been made. We discussed the high numbers of falls at the home. We showed them the care records and told them the limited actions taken. They said, "There are things I don't know, I need to find out more about the falls. We told the provider about one person falling twenty times and they replied, "I did not know they were at such risk of falls." They recognised prompt and urgent action was needed. They said, "I understand how care plans have got so far behind. We need analysis of falls, it's no good jotting it down if we don't take action." They did say, "Some of the things you have said are a surprise, I didn't know [person] had so many falls." The

provider assured us they would look at increasing staffing levels urgently to help with falls prevention.

On the second day of our visit we walked the provider around the home. We showed them some of the environmental risks such as where the exposed electrical wiring was, water temperatures, unlocked chemical storage areas and unrestricted windows we found from the previous day. We also took them outside to see the stones on the entrance roof. They said, "I will get this all sorted today." When we left, the provider arranged for the window restrictors to be fitted and agreed to put plans in place to support the management team.

The registered manager said the provider visited them but there was not a thorough system of checks completed that assured them, improvements were being identified and action taken. For example, the last provider audit stated 'no proper water temperatures checks since May 2015'. These were now in place, however unsafe limits were recorded with no follow up action documented.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was difficult to seek everyone's views because most people were unable to communicate with us due to their health condition. One relative shared their experiences about all aspects of the home. They said, "Good routine here, same staff faces, regular no changes. It is very clean, [person] is always clean, has showers and a bath. Very organised, food is very good. Not many activities (to keep people stimulated). They do communicate if there is a problem and they don't mind me ringing, the phone is always answered. Quite happy with it (Field View) just enough people [residents] here." One person living at the home shared their experiences with us. They had no concerns, and said, "I think it's alright, they don't bother you much, I'm quite content living here."

Staff felt supported and respected by the registered manager and each other. Staff said they could raise any issue with the registered manager and were confident that it would be addressed appropriately in a timely way. Staff said the registered manager was approachable and they could go to them anytime. Staff told us that staff meetings were held and they were productive. Most of the staff said they received one to one meetings, but were not frequent although staff said if they had a concern, they would approach the registered manager without delay. Staff said one to one meetings when held, were useful.

People's individual care records were kept in the manager's office so staff had access to those records and there where kept securely.

We asked the registered manager how they sought people's views about the service. We were told residents meetings were held on a quarterly basis and this had been introduced following our last visit. A relative confirmed to us they knew of the meetings although they had not had chance to attend. Quality assurance surveys had been sent out to people in April 2016 and the provider was waiting to compile the feedback and results. Initial surveys received showed people were pleased with the service they received.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 Registration Regulations 2009 Death of service provider The provider did not notify us that there was a change to the registered partnership or individuals who manage or carry on the service. Regulation 21(1)(2)(a)(b)(3)(a)(b)(4)(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way because risks were not managed and action was not taken to minimise the risks to people's health and wellbeing. Regulation 12 (1)(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there were sufficient numbers of

suitably qualified, competent and skilled staff to meet people's care and welfare needs. Regulation 18 (1).