Prime Life Limited

The Fieldings

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The Fieldings is a care home that provides personal care for up to 47 people, over two floors in one adapted building. It is registered to provide a service to people who have mental health needs. At the time of the inspection 35 people lived at the home.

People's experience of using this service: The service was not safe. People were exposed to the risk of abuse and violence. People were placed at serious risk of harm as risks associated with their care and support and the environment were not managed safely. Opportunities to learn from incidents had been missed which meant people had been exposed to the risk of avoidable harm. The home was in a very unhygienic state and people were not protected from the risk of infection. Staff were not deployed effectively to ensure people's safety. Safe recruitment practices were followed.

People were supported by staff who did not have the required skills or competency to provide safe and effective support. People's physical and mental health needs were not always met. Care and support was not properly planned and coordinated when people moved between services. Care was not always delivered in line with current legislation and standards. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The environment was not well maintained and this posed a risk to people's safety.

People were not treated with dignity and their right to privacy was not upheld. People told us that staff were kind and caring. However, care plans lacked information about people which meant staff did not always have enough information to provide person centred care. There was an inconsistent approach to involving people in decisions about their care and support.

People did not consistently receive personalised care that met their needs. People were not consistently provided with opportunity for meaningful activity. No value or acknowledgement was given to complaints made by people living at the home, as opposed to complaints made by members of the public and relatives.

The provider did not have effective oversight of the home and the manager did not have sufficient time or support. Consequently, there had been a failure to identify and address serious issues with the safety and quality of the service. Systems to monitor and improve the quality of the service were not effective. Where audits had identified areas for improvement, action had not been taken to address issues. The provider had not implemented learning from serious incidents. Failings in leadership and governance placed people at risk of harm.

The service met the characteristics of Inadequate in all areas; more information is in the full report.
Rating at last inspection: Good (report published 14 July 2017).

Why we inspected: We brought this inspection brought forward due to information of concern and a serious incident which occurred at the home.

Enforcement: You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor intelligence we receive about the service until we complete our next planned inspection. If any concerning information is received we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

The Fieldings

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of a serious incident. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

Inspection team: This inspection was carried out by three inspectors and an inspection manager.

Service and service type: The Fieldings is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, however, they were absent from the home and an acting manager was in post. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we reviewed any notifications we had received from the service and information from external agencies such as the local authority. We did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us to give key information about the service. We gave the provider and acting manager the opportunity to share this information during the inspection.

During our inspection we spoke with nine people who lived at the home. We also spoke with six staff, the

acting manager, the regional director and members of the provider's quality and compliance team. We reviewed records related to the care of 13 people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, three staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information from the provider. This was provided within the requested timeframe.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
• People were exposed to the risk of sexual violence. There were several people who posed a risk to others. Behaviour records documented multiple threats and actions directed towards people living at the home and staff. There had been a failure to learn from these incidents to mitigate the risk to others. Risk assessments and measures in place to mitigate risk were insufficient and ineffective. There had been a recent serious incident in which a person had sustained harm, this had been investigated by the local authority safeguarding team who found the provider had not taken appropriate action to safeguard people from abuse. This incident was also subject to a police investigation.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;
• People were not protected from the risk of harm as risks associated with smoking and fire were not managed safely. Several people were known to smoke in their bedrooms and there were specific risks posed by some people who were known to set fire to things. We observed extensive evidence of people smoking in their rooms including burns to flooring, bedding and clothing. Some people's rooms posed a further risk due to an accumulation of combustible items. Individual smoking risk assessments did not reflect the level of risk, nor did the overall fire risk assessment and consequently there were insufficient measures to ensure people's safety.
• During our inspection Nottinghamshire Fire and Rescue Service conducted a fire safety audit at The Fieldings. This identified additional concerns with the means of escape, failure to comply with the fire safety policy, damaged fire doors, an inaccurate fire evacuation strategy and failure to make environmental adjustments to reduce the risk of fire. The above issues placed people at risk of serious harm.
• People were not protected from other environmental risks. We observed damaged heaters, with sharp exposed metal work in two people's bedrooms. Both bedrooms were in an unhygienic state with fluids on the floor, this increased the risk of people slipping and sustaining an injury. Furthermore, we found dangerous items left throughout the home which could have led to accidental or intentional injury. This placed people at risk of harm.
• Risks associated with people's behaviour were not effectively managed. One person was known to behave in a way that placed others at risk of harm. There were five incident records from the past five months where the person had verbally or physically assaulted others. Their behaviour support plan did not provide sufficient guidance about how to reduce risk. Patterns of behaviour had not been identified or planned for.
• Adequate action was not taken to protect people from harming themselves. One person regularly caused intentional injury to themselves. There was a lack of effective risk reduction measures in place. Incident records documented an incident where the person had asked for help but staff had not provided adequate

care, resulting in them causing harm to themselves. This may have been preventable.

Preventing and controlling infection;
• People were not protected from the risk of infection. Throughout our inspection the environment was in a very unhygienic state, this was to the point that it could pose a risk to health. Toilets were stained, bodily fluids were observed to be all over some bedroom and ensuite floors, the communal kitchen was very dirty and we observed a member of staff using dirty water to clean a bedroom floor. Furthermore, there was very limited access to personal protective equipment such as gloves and aprons and there were other unhygienic practices. These issues significantly increased the risk of infection spreading.

Learning lessons when things go wrong
• Opportunities to learn from incidents had been missed. Consequently, people were placed at risk of harm. Incident records had not been reviewed by a senior member of staff and learning from incidents was not considered when updating support plans. For example, incident records showed one person frequently left the home without informing staff. This had resulted in the police being called. Despite this, there was no missing person's profile for this person, which meant there was no coordinated way of sharing information with the police.

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

Staffing and recruitment
• Although there were enough staff available they were not deployed effectively to ensure people's safety. There was a lack of staff supervision in communal areas, such as corridors. People who posed a risk to others were left unsupervised with other vulnerable people. This placed people at risk of harm. Incident records documented incidents of verbal and physical altercations which had taken place in communal areas unwitnessed by staff.

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

• Safe recruitment practices had been followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

Using medicines safely
• Medicines were managed safely and records showed people received their medicines as prescribed. People told us they got their medicines when they needed them.
• Information was available for staff about how each person preferred to take their medicines and any allergies they had. Medicine records indicated people took their medicines regularly as prescribed. Staff received regular training in medicines administration.

Inadequate

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
• Staff were not appropriately competent, skilled or experienced to provide support to meet people's needs or ensure their safety.
• Staff did not have training in key areas. Only 44% of staff were trained in safeguarding and only 48% were trained in mental health awareness. Furthermore, although incident records and care plans documented that several people behaved in ways that placed others at risk of harm, staff did not have any training in positive behavioural support or dealing with behaviours that challenged. These deficiencies in training had a negative impact upon the quality and safety of the service.
• Training had not always been effective in ensuring staff competency. For example, the training matrix showed that most staff had received infection control training. However, throughout our inspection we identified serious concerns about infection control. Staff had received food safety training, however, we observed poor food hygiene practices during our inspection.

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

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People did not receive the support they required in relation to their mental health. Mental health support plans did not convey how frequently people's appointments with the mental health team should be, how to contact the mental health team in a crisis and advice from specialist health professionals was not incorporated into support plans. Furthermore, we received feedback from external health professionals that staff were not proactive in accessing their support. They told us that referrals were reactive, rather than proactive, resulting in people only being referred when in crisis.
• There was evidence that staff supported people to attend healthcare appointments. However, during our inspection external health professionals raised concerns that staff failed to identify the need for support from physical health professionals due to a lack of skill and guidance. This had resulted in people choosing not to access healthcare and a consequent negative impact upon their health.
• Staff did not actively encourage people to live healthy lifestyles. For example, several people smoked, there was no evidence they had been offered support to stop smoking. Several people misused alcohol, this had become an accepted culture and there was little evidence that staff encouraged people to reduce their alcohol intake.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Although assessments of people's needs were completed prior to them moving into the Fieldings, these were not always effective. This had resulted in inappropriate placements. This view was shared by visiting health professionals who told us they felt there were people living at the home that staff did not have the skill or competency to support effectively. They told us this had resulted in a higher than average breakdown of placements or recall to inpatient settings. This did not meet people's needs.

Adapting service design and decoration to meet people's needs
• The service was not adapted to meet people's needs. Several people were known to smoke in their bedrooms. Despite this known risk, action had not been taken to ensure suitable fire precaution measures such as fireproof bedding or extinguishers.
• Some areas of the environment required urgent maintenance to ensure people's safety. This had not been identified before our inspection.
• There was limited signage to enable people to find their way around the home and the approach to personalisation was inconsistent. For example, upstairs there was no signage to identify people's bedrooms.

Supporting people to eat and drink enough to maintain a balanced diet
• Food hygiene practices were not always followed. We observed staff serve food directly on to the table with no plate. This was not hygienic or dignified.
• During our inspection we were notified of concerns that professional guidance to reduce the risk of a person losing weight had not been followed. This was under investigation at the time of writing this report.
• Overall, people were positive about the food and said they were offered a choice. A member of the catering team explained how they developed menu choices and told us they would cater for people's individual preferences if required.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Further work was required to ensure people's rights under the MCA were respected. Some capacity assessments had been conducted when people's ability to consent was in doubt. However, this was inconsistent as capacity assessments were not in place in all areas where people were unable to consent to restrictions on their freedom.
• DoLS had been applied for as required. Many DoLS were still awaiting authorisation. Where conditions were in place these were complied with.

Inadequate

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

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity;
Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care;

• People's right to privacy was not respected. Many bedroom windows looked directly on to the courtyard, the car park and the street. No consideration had been given to ensuring people's privacy was respected. One person told us, others frequently looked through their bedroom window and stated this was a problem if they forgot to fully close the door when using the toilet. This resulted in a lack of privacy.
• People's dignity was not always upheld. Throughout our inspection we observed areas of the home to be in a very unhygienic state, not only was this an infection control concern but allowing people to live in such circumstances was undignified. For example, the kitchenette which people made their drinks in was in an unhygienic state and there was no cutlery or crockery available so people had to bring their own.
• Some people's bedding was in a very poor state. Some bedding and mattresses had burn holes in them and some duvets, sheets were dirty and stained. This had not been identified and consequently was not addressed. This did not promote people's dignity.
• Staff did not always promote people's dignity. We observed staff serving lunch. Staff did not try to create a positive and sociable dining experience. People were served food without first being given cutlery and some food was served straight on the table. This was not dignified and did not uphold people's right to be treated with respect.
• People did not always have adequate clothing. One person told us they had been wearing their shoes with no socks as they did not own any socks. This had caused significant damage to their feet. This had not been identified by staff and consequently it was not addressed. Staff then provided the person with poor condition socks labelled with another person's name. This was not dignified.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were not supported and encouraged to grow in independence. There was a lack of discharge planning and the service was not focused on a model of recovery and independence. Care plans were not clear in how they promoted and prepared people to live independently. For example, a document dated January 2019, recorded a person wished to move to more independent living. We observed there were no plans in place to support progress towards this goal. There was no evidence of a proactive, recovery based approach to care.
• Staff did not take natural opportunities to engage with people. We observed staff were present in

communal areas, primarily in a supervisory capacity. Although staff were friendly in their approach, they did not take opportunities to meaningfully engage with people. This did not meet people's needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's feedback about involvement in decisions about their care was mixed. Some people told us their choices were respected, however, others commented that they did not always feel listened to.
• Feedback about involvement in support planning was also varied. One person told us, "No I haven't see mine (support plan) for a long, long time, they keep a file on you that you are not allowed to see. They show me the day to day write up, but they don't show you the other stuff." In contrast, other people told us they had seen their support plans but had not been involved in developing them.
• Support plans were focused on need and contained very little information about people's identity or what matter most to them.
• People had access to advocacy if they needed it to help them express their needs. The acting manager told us advocacy was discussed in resident and staff meetings to ensure people were aware of this.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People did not always receive the care they needed. Throughout our inspection we found concerns about the level of care provided. Care plans were poor and staff were not providing the care specified in care plans. For example, one person's care plan stated they needed support in a number of areas, including personal care. However, a staff member told us they did not really provide any support to the person other than occasional reassurance. This did not meet the person's needs.
• Care and support was not always focused on people's preferences and goals. For example, one person wished to reduce the amount they smoked and drank. There was no plan in place to support them to take steps towards their goal. This was in direct conflict with their behaviour support plan which directed staff to encourage them to have a cigarette when they became agitated.
• People lacked opportunity for meaningful activity and occupation. People told us about trips out and celebratory events, but day to day activity was limited. Throughout our inspection there was a lack of stimulation and planned activity. There was no coordinated approach to providing people with opportunities and we observed many people spent their time unoccupied, wandering or withdrawn. For example, we observed a member of staff enter a communal area and state, "Right who wants to go out," no one responded and the staff member left the room without providing any further encouragement.
• There was a gym on site; however, staff told us this was only used about three times a week and staff had not had training on how to safely support people to access the gym. This was unused and locked throughout our inspection.
• The acting manager told us support with activities was flexible to suit people's needs; however, this approach did not consider the fact that many people lacked motivation to initiate activity. This did not meet people's needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There had been some work to help the people living at the home be better included in the community. For example, a local police community support officer visited the home regularly to meet with people. Despite this people still faced some discrimination.

Improving care quality in response to complaints or concerns
• People's complaints and concerns were not treated fairly. Throughout our inspection several people told us they were not happy living at the home or said they had previously raised complaints and concerns to staff or the management team. One person told us, "[The acting manager] doesn't do anything if I go to them with complaints." Despite this there was no record of any complaints from people living at the home. Complaints records were only kept for complaints raised by members of the public and others such as

relatives. This failure to apply the complaints policy fairly was discriminatory and posed a risk that people's concerns and complaints may not be acted upon.

End of life care and support

• There was no evidence of end of life planning and staff did not have training in this area. Most people living at the home were younger adults and were not coming towards the end of their lives. However, a lack of training meant opportunities to support people coming towards the end of their life in the future may be missed.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness and how the provider understands and acts on their duty of candour responsibility;
• During our inspection of The Fieldings, we found widespread and significant shortfalls in the way the service was governed. There had been a lack of effective leadership and management at The Fieldings.
• There was a culture of complacency. Many of the risks found throughout our inspection, such as smoking in bedrooms and poor infection control and cleanliness, had been overlooked by staff and the management team as they had become accepted as part of the culture of the home. Furthermore, there was a little focus on recovery and independence. The provider's vision, to provide a high-quality standard of living tailored to clients' individual needs was not evident at The Fieldings. This had resulted in people receiving poor quality, unsafe care. There was evidence of discriminatory practices within the home, such as not valuing and acknowledging complaints from people living at the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• There had been a total failure of governance systems to identify and address serious risks to people's health and safety. Consequently, leaders were out of touch with the issues at the home. An audit conducted by the provider's quality and compliance team in April 2019 did not identify the serious issues we cited in this report. An internal infection control audit completed in April 2019 had scored the home at 92%, issues with the cleanliness of the environment and infection control practices had not been identified. This failure to identify and address issues placed people at risk of harm.
• There was little evidence of learning, reflective practice and service improvement. The provider did not have robust systems in place to review and learn from incidents. Although some incidents such as falls were reviewed, many significant incidents were not included which meant opportunities for learning had been missed. This had resulted in a failure to effectively mitigate risk. Furthermore, when incidents had been reviewed appropriate action had not been taken in response. For example, incident analysis documented a recent arson attempt. Despite this, action had not been taken to implement control measures to reduce this risk. This failure to act placed people and staff at risk of harm.
• The provider had failed to take effective action to mitigate serious risks. We wrote to the provider after our first day of inspection asking them to take urgent action to mitigate the most serious risks. However, during our second day of inspection on 15 May 2019 we found continued, serious concerns in these areas.
• Throughout our inspection the provider's response to risk management was reactive and did not always uphold people's rights or ensure their safety. For example, in response to our concerns about smoking and fire risk, the provider implemented a 'three strikes and you're out' rule. However, this did not take people's mental capacity and mental health needs into account and was consequently punitive. In response to

feedback from the fire service about escape routes, the provider removed the garden gate which meant the garden was no longer secure, no consideration was given to ensuring the safety of people who were not safe to leave the service alone.
• The acting manager was subject to frequent interruptions, they did not have any day to day managerial support, such as a deputy manager or support with administrative duties and the two seniors were relatively new in post and so were unable to offer effective management support to the acting manager. This meant that many planned improvements to the safety and quality of the home had been delayed.

Working in partnership with others;
• The provider had not taken action in response to concerns raised by partner agencies. Many issues found during our inspection were identical to those found by the CCG and Infection Control Team in early 2019. These issues had not been addressed and remained a risk. Furthermore, we received concerns from health professionals during our inspection about a failure to engage with the services offered by them.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home, they did not have website. We checked our records which showed the provider had notified us of events in the home as required. This helps us monitor the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
• People were involved in some decisions about the home. Regular meetings were held where people were given the opportunity to share their views about the home. The acting manager acted upon people's feedback, for example, one person had suggested improvements to the dining experience and the acting manager told us they were planning to make changes. People were also invited to share their feedback in regular quality assurance surveys.
• There were regular staff meetings, these were used to share news and information with staff and to discuss areas of concern and improvements needed.