Friary Fields Limited

Friary Fields Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Friary Fields Care Home is a care home that provides personal care and nursing for up to 34 people in one adapted building. At the time of the inspection 21 people lived at the home.

People's experience of using this service and what we found
People were not safe at Friary Fields. The environment was not safe. People were placed at risk of serious harm due to elevated fire risk and inadequate fire risk management. There was an increased risk of legionella developing in water supply and people were exposed to the risk of sustaining burns due to a failure to manage risks associated with hot water and exposed hot surfaces.

Risks associated with people's care and support were not managed safely. Measures were not in place to reduce risks associated with falls, health conditions, moving and handling and pressure ulcers. Equipment was not always used safely or effectively. For example, some people were unable to call for help as call bells were not within their reach. These issues placed people at risk of harm.

People were provided with care which was degrading and disregarded their need for care and support. Staff were not deployed effectively to meet people's needs and ensure their safety. Furthermore, staff worked long shifts, back to back which could have led to exhaustion and compromised people's safety. Medicines were not managed safely, and some people did not receive their medicines as prescribed. The home was not clean and good food hygiene practices were not followed. This could have had a negative impact upon people's health.

The home was not well led. The provider did not have the skills, competency or resources to run Friary Fields Care Home. People's health and safety was at risk due a failure to identify and address issues and poor practices. Although we found that the service worked with partner agencies, feedback from professionals was poor. Information had not always been shared in an open and honest way with people, their families or staff.

Following our inspection the local authority made arrangements for people to be moved to new homes.

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

Rating at last inspection
The last rating for this service was requires improvement (published 11 September 2019) and there were multiple breaches of regulation. Following this inspection we served two warning notices on the provider in relation to safe care and treatment and governance.

Why we inspected
The inspection was prompted due to concerns received about safety, quality and leadership. A decision was

made for us to inspect and examine those risks.

Enforcement
We have identified three breaches of the legal regulations. These were in relation to safeguarding, safe care and treatment and governance. 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 information we receive about the service. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Friary Fields Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried one inspector. Representatives from the local authority and the Fire and Rescue service were also present during our inspection.

Service and service type
Friary Fields Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of inspection, the service had a manager registered with the Care Quality Commission, however, the registered manager was absent from work. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

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 registered manager the opportunity to share this information during the inspection.

During the inspection
We spoke with six people who used the service. We spoke with six members of staff including a senior care worker, care workers, catering and housekeeping staff and the company directors.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at records of accidents and incidents, quality assurance systems, 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.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were placed at risk of serious harm due to elevated fire risk and inadequate fire risk management.
- Some fire doors were locked, exit routes were not clearly signposted, fire extinguishers were not fit for purpose, there was a lack of fire detection in some areas, staff did not know how to evacuate people safely and the fire risk assessment was inadequate.
- The risk of fie was increased as some people smoked in their bedrooms and there were no measures in place to reduce the risk.
- People were at risk of sustaining burns or scalds as water temperatures exceeded recommended limits. . For example, water in a bath was in excess of 50 degrees, this posed a risk of scalding when bathing. There were hot surfaces, such as piping, and radiators not covered which placed people at risk of burns.
- There was an increased risk of legionella developing in the water supply. There were multiple water outlets, which were inaccessible for flushing. We also saw heavy limescale to multiple water outlets. These issues increased the risk of bacteria growth. There was no evidence of regular maintenance or water treatment and checks and the provider was unable to provide us with a risk assessment in relation to this.
- People were exposed to the risk of harm as a result of falls. This risk was exacerbated by environmental risks, such as unrestricted stairwells and the failure to implement control measures when a high falls risk was identified. For example, we found a person at the top of a small flight of stairs with their walking frame hanging over the first step. No staff were present, and we had to intervene to ensure their safety. Several other people had been assessed as being at a high risk of falls. Despite this, there were no risk reduction measures in place.
- People were at risk of developing pressure ulcers. A risk assessment showed one person was at high risk of pressure sores and required assistance to reposition every 2-3 hours. We saw they were left in their chair for a period of seven hours with no evidence that they were repositioned.
- People were at risk of harm due to poor moving and handling. We saw a person being pulled backwards in a wheelchair, no footplates were in used and their feet were dragging on floor, this could have led to injury. Slings in use did not match those specified in care plans and we saw some slings were dirty and in poor condition.
- Risks arising from health conditions were not managed safely. One person, experienced seizures. There was no care plan or risk assessment in place in relation to this. There were no measures in place to alert staff to seizures and the person was only checked every two hours. This meant the person could suffer a seizure and be left for up to two hours without support.
- Equipment was not always used safely or effectively. Call bells were not always accessible to people. One person was left in their room with no way to call for assistance. They told us this was a regular occurrence.

Bed rails were not used safely as the risk of people climbing over them had not been considered.
● People were at risk due to poor food safety and hygiene. We found out of date food and undated food in the fridges. Some areas of the kitchen were unhygienic, with heavy dust and debris on the floor and food encrusted on to the top of the microwave.

Using medicines safely
● Medicines were not managed safely, and some people did not receive their medicines as prescribed.
● There had been a failure to address issues where people were not available to take their medicines. One person had not had any of their morning medicines for over a month as they were marked as being on 'social leave'. This included essential medicines such as those for mental health and prevention of stroke or heart attack. Action had not been taken to address this. This posed a risk to people's physical and mental health.
● Medicine administration guidance was not followed. One person's care plan stated staff must watch them swallow medicines. However, we saw the person had retained the tablet in their mouth.
● There had been a failure to order medicines in a timely manner, this had resulted in one person running out of pain medication.
● Medicine records were not completed at the time of administration. A member of staff told us this was due to interruptions. This increased the risk of errors occurring when dispensing the medicines.
● Medicines were not stored safely. A large volume of refused medicines were stored in the medicines trolley. No record was kept of what was contained in the box, this increased the risk of accidental or intentional misuse. Furthermore, medicines were stored above the recommended temperature. This could have had a negative impact upon the effectiveness of the medicines.

Learning lessons when things go wrong
● Opportunities to learn from incidents and improve practice had been missed. For example, records showed one person had a recent fall, but care records did not contain evidence of any action taken to reduce risk, there was no increase in welfare checks and no risk reduction measures implemented. Incident records showed they fell again and sustained a fracture.

Preventing and controlling infection
● People were not protected from the risk of infection. Issues such as bodily substances on bathroom walls, equipment and bedding and blood on slings amounted to a health risk.
● Two people had possible infections and there were no control measures in place. There were not enough staff to keep the home clean.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were provided with care which was degrading and disregarded their needs for care and support.
● During our inspection, the local authority took steps to move everyone to new homes. We received concerns about people's welfare from the new care providers. For example, we received reports of people being in poor physical condition with dirty hair, nails and clothing. This neglect of people's basic care needs was degrading and showed a disregard for their wellbeing.

The failure to protect people from improper treatment and abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff employed. This had resulted in some staff working long shifts back to back. For example, one member of staff had worked 27 of the 28 days leading up to our inspection, 19 of which were 13.5 hour shifts. This posed a risk that staff may become exhausted, compromising the safety of the service.

● Although records showed there were normally enough staff on shift to meet peoples, staff were not deployed effectively to ensure people's safety or wellbeing. For example, we observed several occasions where people were placed at risk of harm as there were no staff present to ensure their safety. .

● Before our inspection we received concerns that safe recruitment practices were not followed. We were unable to make a judgement about the safety of recruitment practices as the provider did not have access to staff files and they were unable to offer any assurances about recruitment.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider did not have effective systems in place to ensure the safety and quality of care provided to people. Because of this, the provider had not identified serious concerns about the quality and safety of the home which are detailed in this report. This had a negative impact upon the safety and quality of care provided to people.
- Opportunities to learn from incidents, address poor performance and improve practice had been missed. Analysis of falls and other incidents had not been conducted. This meant themes and trends of incidents had not been identified to consider the prevention of risk.
- The provider did not have access to documentation to ensure the safe and effective running of the home. Key documents, such as staff files, training records and governance records, were locked in a filing cabinet, for which provider did not have a key. This meant the provider could not assure themselves or us that staff were recruited safely or trained to an adequate standard.
- During our inspection, we wrote to the provider outlining our most serious concerns and requesting that action was taken to address this. The provider did not respond to this and said they could not achieve the improvements required. This demonstrated the provider did not have the skills, competency or resources to run Friary Fields Care Home.
- The quality of care deteriorated further over the inspection period. The local authority stepped in to ensure the safe and effective running the home, during this time they told us that the provider had not taken any action to reduce risks to people and that some risks had increased. The provider had stopped providing basic care to people.

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

- There was insufficient leadership and governance at Friary Fields Care Home. The registered manager had been absent from work since late August 2019 and there was no planned date of return. No interim manager had been employed. A member of care staff had been helping to manage the home, but they did not have enough time to do so effectively as they were also providing care to people. This meant there were insufficient measures in place to ensure the safe and effective running of the home in the absence of the registered manager.
- There were no clear lines of accountability within the home. For example, at the time of our inspection no one was responsible for care planning and consequently care plans did not reflect people needs. No one was responsible for auditing, so there were no governance systems and consequently issues we have

reported on had not been identified.

Working in partnership with others
● Feedback from partner agencies was poor. External professionals told us the home was disorganised and this had a negative impact upon care. For example, the paperwork for a person's medication had been lost which meant the health professional was unable to administer the medicine causing a delay in treatment. The health professional told us this was a regular occurrence.
● There was no evidence that the provider worked in partnership with others to keep up to date with good practice. Consequently, we found numerous examples of poor-quality care which did not reflect up to date best practice guidelines.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Although people's relatives were, overall, positive about the caring approach of staff at Friary Fields, there were no effective systems to involve people and their relatives in the running of the home. Records of meetings planned for people and their families showed that no one had attended these in the past 12 months. There was no evidence that other ways of involving people had been considered or tried.
● There was no evidence that the provider had shared the outcome of our July 2019 inspection, or what they were doing to make improvements, with people, their families or staff.
● The provider did not always act on their duty of candour. A relative told us that the provider had not informed them about significant incidents involving their relation. This meant they did not feel fully informed about the care of their relative and lacked confidence in the provider.
● We were not provided with evidence that staff had been consulted with or informed about the running of the home. Some staff told us that the provider did not always communicate in an open and honest way with them.

The failure to ensure good governance and leadership was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had notified us of events as legally required.
● 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.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with safe care and support. A failure to manage environmental risks placed people at serious risk of harm. People were at risk of infection. Regulation 12 (1)

The enforcement action we took:

We took urgent action to restrict admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were provided with care which was degrading and disregarded their need for care and support. Regulation 13(1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have the skills, competency or resources to run Friary Fields Care Home. People's health and safety was at risk due a failure to identify and address issues and due to poor practices. Regulation 17(1)

The enforcement action we took:

We took action to cancel the registration of the provider.