Field House

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Inspection report

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10 April 2017

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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

This inspection took place on 10 April 2017 and was an unannounced focused inspection to follow up concerns raised to us with regard to the safety of the people living at the service. Field House provides accommodation and personal care for up to 12 people who live with a learning difficulty. On the day of our inspection six people were using the service.

At previous inspections we found the provider to be in breach of a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Our inspection focused on those regulations specific to the concerns which were raised to us. As a result we did not follow up on the breach of Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

The service did not have a registered manager in place at the time of our inspection and has not had one since the service was registered with the Care Quality Commission in 2010. 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.

Our inspection focused on the environmental and personal safety of the people who lived in the home following serious water damage to the property and whether the provider had met the legal requirements in protecting people from unnecessary risk.

We found people were not protected from risks to their safety as the provider had not assessed the risks which had occurred as a result of a significant leak and damage to the premises.

There was a lack of regular maintenance of the building which had led to areas of the home and the fixtures and fittings being in poor repair. There was a lack of environmental audits which would have highlighted these shortcomings and possibly prevent the subsequent damage to the property. The provider showed a lack of oversight in regard the safety of the people who lived at the service and was slow to respond and support staff in times of crisis.

The provider did not fulfil their legal responsibilities to inform us of significant events that affected the safe running of the service.

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.

The premises were not maintained to provide a safe environment for people.
The provider had not assessed the risks to people's safety and people were at risk of harm.

Is the service well-led?

Inadequate

The service was not well led.

There was not a registered manager in post and the provider did not undertake quality audits or analyse events to ensure the service provided a safe standard of care.

The provider had not notified us of events that had taken place in the service they were required to inform us about.

Field House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Field House on 10 April 2017. This inspection to follow up concerns raised to us with regard to the safety of the people living at the service. We inspected the service against two of the five questions we ask about services: Is the service safe and is the service well led?

The inspection was carried out by one inspector.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with one person who used the service, two members of care staff, and the home manager. We carried out observations of the service and toured the building. We looked at the care plans of two people and asked to view a range of other records relating to the running of the service, such as audits and maintenance records.

Inadequate

Is the service safe?

Our findings

When we previously inspected the service in December 2015 and December 2016 we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found areas of the building were not being adequately maintained. At this inspection we found people who lived at the service were still not in a safe environment. During our visit we found the environment was not maintained to the standard we would expect from the provider. In recent weeks there had been a significant number of incidents that had affected the safety and wellbeing of people. These were all caused as a result of extremely poor long term maintenance of the premises by the provider.

There was a serious leak from the roof space on the third floor which started on the 24 March 2017 and was still visible during our visit. This had affected a number of rooms used by people. On the 6 April 2017 a ceiling had collapsed in a downstairs bathroom which contained the only shower on the premises and the only toilet on the ground floor. This caused significant water damage to the dining room on the ground floor and a bedroom on the floor above the dining room. As a result of this damage the home manager had taken these rooms out of use for the people who lived at the service. We asked what measures had been undertaken to repair the leak and were told that although a plumber had been called out, no repairs to the leak had taken place. This was due to the disruption the repairs would cause to people who used the service.

The people who lived at the service were in the process of being re-located to other placements as the local authority had terminated their contract with the provider. As a result the provider had decided to wait until the people who used the service had left before undertaking any repairs. The only measures taken to reduce the damage to the property was to cover the bathroom roof with plastic. This was done by a member of staff leaning out of an upstairs window and throwing the plastic over the roof. The plastic was not fixed securely and had not been effective as a means to reduce water damage occurring.

We were told by the manager the outside of the building had been showing some evidence of a slow water leak from the time they had started work at the service in November 2016. There was no evidence and the manager was unaware of any inspection or investigation of this issue by the provider during this time although they told us the provider was aware of the issue. Investigation of the leak at that time could have prevented the serious leak that caused the significant damage to the premises and put people at significant risk of harm.

The failure to properly maintain the premises is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were further issues of concern relating to the safety of people living at the home. Whilst we saw the rooms affected by the leak had been taken out of use for the people who lived at the service they had not been locked to prevent people from being able to access them, which placed them at risk. Furthermore, people's medicines were still being stored in the dining room. This meant staff were required to regularly enter this room to fetch people's medicines when they needed these. The dining room was situated next to

the bathroom and showed significant water damage to the adjoining wall and part of the ceiling. This coupled with the fact there was still a serious leak presented an ongoing and serious risk to the people who lived at the service and staff who worked there. We highlighted the risk to staff who told us they were planning to put bolts on these doors. This had not been done when we left the service and no consideration had been made with regard to finding a more suitable place to safely store people's medicines.

At our previous inspection we found there were no PEEPs (Personal emergency evacuation profiles) in place for people. This presented a risk that during an emergency people may not be supported to evacuate the building effectively. At this inspection the manager told us the PEEPs had been completed but there were no copies either the emergency evacuation file or in people's care plans and after extensive searching the manager confirmed they were not available. This presented an ongoing risk to people who lived at the service. We asked to see records of regular fire drills and these could not be produced. One member of staff who had recently been employed by the service told us they had not received any fire safety training, had not undertaken any fire drill or experienced a fire alarm test.

The provider had failed to undertake reasonable measures to mitigate risks to people's safety and had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

During our inspection visit we checked the fire doors on each floor were functioning correctly. The doors could be opened from the inside by use of a release bar on the door. The people at the service were aware of how they should evacuate the building should this be required. One person we spoke with was able to show us their fire exit route. We also checked the fire alarm was functioning effectively by requesting the staff undertook a fire alarm test whilst we were present. The test was successful.

Inadequate

Is the service well-led?

Our findings

There was a lack of leadership at the service and this impacted on the day to day running of the home. There was no registered manager in post at the time of the inspection and there had been no registered manager in post since the service had been registered with the Care Quality Commission (CQC) in 2010. The present manager who had started work at the service in November 2016 had started the process of registering as manager with ourselves (CQC) but this had not been progressed due to the planned closure of the service.

Our discussions with the manager showed they lacked some of the knowledge and skills required to effectively carry out their role and had not been adequately supported by the provider to acquire these skills. For example during our last inspection we saw there had been some incidents that had occurred at the service which should have been reported to us as part of the provider's legal obligation and the provider was in breach of Registration Regulations 18 (2) (a) Care Quality Commission (Registration) regulations 2009.

Prior to this inspection the local authority informed us of the safety issues relating to the leak at the property and collapse of the bathroom ceiling. When we contacted the manager they told us they did not know how to report these occurrences and following advice from the local authority had sent an email to their CQC inspector to inform them of the incident. Also at this inspection we found further incidents such as the boiler breaking down had occurred but not been reported. We also saw records to show a boiler at the service had broken down in December 2016. The boiler supplied hot water to the premises and was not fully repaired until February 2017. Staff at the premises had to use an alternative emersion heater to provide hot water for people in their care during this time. This had not been reported to us and meant the provider's legal responsibilities had not been met concerning statutory notifications that are required in accordance with the regulations.

This was a continued breach of Registration Regulations 18 (2) (a) Care Quality Commission (Registration) Regulations 2009.

During our previous inspections in December 2015 and December 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there was a clear lack of management and leadership in the service and the culture was not open and transparent. We found there was no system in place to monitor safeguarding incidents, to monitor if staff followed the complaints procedures and no systems in place to monitor and audit the maintenance work that needed to be done to the premises.

During this inspection we found the risks for people relating to the damage of the property both personal and environmental had not been assessed and analysed thoroughly by the provider. A complete and thorough risk assessment by the provider of this serious issue with clear actions and areas of responsibilities was required and this had not been undertaken. This would have provided focus on the priorities and given clear areas of responsibility for the provider, manager and staff to reduce the risk to people, visitors and staff safety.

We asked for records of environmental audits which would show how the provider and manager had monitored the quality of the environment and taken actions to rectify any issues of concern. The manager told us they had not undertaken any environmental audits, other than daily checks on the fire doors, and had not witnessed the provider undertaking them. This lack of oversight had placed people, visitors and staff at risk of harm as during our visit we saw hazards that could affect the safety of the people using the service. For example when we walked around the service we saw one stair leading to the second floor was badly damaged and was a serious trip hazard. The lighting in that area of the home was poor and we were told the stair had been damaged for some time. The manager told they had moved a person who had a room beyond that area when they first started at the service to ensure they were not continually using that staircase. However there were no plans in place to repair the stair and the area had not been cordoned off. There were no signs to show there was damage to the stair and people and staff were still able to access the staircase. This presented a very real ongoing risk to people and staff safety.

This failure to asses, monitor and improve the quality and safety of the service to reduce the risks to people, visitors and staff safety is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our discussions with the manager about the provider's actions following the leak on the 24 March 2017 showed that whilst they had authorised a plumber to be called to assist staff manage the incident they had not attended the property to see the extent of the damage until the 4 April 2017. Following the collapse of the ceiling on the 6 April 2017staff tried to contact the provider, however they could not establish contact until the following day. This meant there was a lack of support for staff during a difficult and dangerous incident.

Prior to and during our inspection we tried to contact the provider to establish what measures they had taken to protect the people and staff at the service as a result of the damage to the property. We were unable to establish contact despite numerous attempts. On the day of our inspection we contacted the health and safety team at Nottingham City Council as we could not be assured the electric supply to the premises was safe. Our discussion with the manager showed they were not aware that the electrical system had been checked for safety by a qualified professional. Prior to the completion of our inspection we received assurances from the health and safety team and the provider that a certified electrician had undertaken a full extensive test and visual inspection of the electrics of the down stairs bathroom on the 7 April 2017, a day after the collapse of the ceiling. We relayed this information to the manager before we left the property.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not met their legal responsibilities concerning statutory notifications that are required to be reported to the Care Quality commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to undertake reasonable measures to mitigate risks to people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to asses, monitor and improve the quality and safety of the service to reduce the risks to people, visitors and staff safety. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises