# Field House (EYE) Ltd

# Field House

**Inspection report**

Eyebury Road, Eye,
Peterborough, Cambridgeshire, PE6 7TD
Tel: 01733 222417
Website: www.fieldhousecare.co.uk

Date of inspection visit: 23 and 29 July 2015
Date of publication: 07/09/2015

## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Requires improvement** |
| Is the service caring? | **Requires improvement** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection was carried out on 23, and 29 July 2015. Our last inspection was a desk top review that took place on 15 July 2014 and the service was found to be compliant in the areas we looked at.

Field House is a care home registered to provide accommodation and personal care for up to 33 older people some of whom are living with dementia. Field House also provides a domiciliary care service to people living in their own homes within the village of Eye. There were 33 people living at the home at the time of our visit and four people supported with personal care within their own homes. Accommodation in the care home is provided on two floors with stairs and a lift as access. The majority of people shared communal toilets and bathrooms, twenty bedrooms have en-suite facilities. There are internal and external communal areas, including lounge / dining areas, and a garden for people and their visitors to use.

There was a registered manager in place. They had been in place since 1987 and had been registered since August 2011, when the provider registered as a limited company. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The registered manager was aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions. There were systems in place to assess people's capacity for decision making. Appropriate applications were made to the authorising agencies to ensure that people's rights were protected. The majority of staff were not aware of the requirements of the MCA 2005.

People who lived in the home were supported by staff in a kind way that maintained their safety.

They had care and support plans in place which recorded their likes and dislikes, needs and wishes. People's privacy was respected; however people's dignity was sometimes compromised.

Risks to people were identified by staff to enable people to live as safe a life as possible. People deemed at risk were referred to the appropriate external health care professionals for support and guidance. There were arrangements in place for the safe storage, disposal, management and administration of people's prescribed medicines.

People were supported to eat adequate amounts of food and fluid to make sure that they were not at risk of malnutrition and dehydration. The quality of the food was variable and there were limited menu choices for people.

Some areas within the home were not clean. This increased the risk of cross contamination due to poor infection control.

There was an 'open' culture within the home. People, their visitors and staff were able to raise any suggestions or concerns that they might have had with the registered manager and felt listened too.

There were a sufficient number of staff on duty. Staff were trained to provide effective care which met people's individual care and support needs. Staff understood their role and responsibilities to report poor care. Staff were supported by the registered manager to maintain and develop their skills through supervision and training.

The registered manager had in place a quality monitoring process to identify areas of improvement required within the home. However, these checks were not always formally recorded with an action plan.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not always safe.

Areas of the home were not always kept clean.

Staff knew how to make sure that any identified risks for people were reduced. Staff were aware of their responsibility to report any safeguarding concerns.

People's support and care needs were met by a sufficient number of staff. Staff were recruited safely.

Medicines were managed and administered safely.

**Requires improvement**

**Is the service effective?**
The service was not always effective.

People were supported by staff to eat a nutritional diet and drink fluids. The quality of the food was variable with limited menu choices for people.

Appropriate applications were made to the authorising agencies to ensure that people's rights were protected.

Staff were trained to provide effective care and support to people.

**Requires improvement**

**Is the service caring?**
The service was not always caring.

People's privacy was respected by staff. People's dignity was sometimes compromised.

Staff were kind and respectful in the way that they supported people.

Staff encouraged people to make their own choices about things that were important to them.

**Requires improvement**

**Is the service responsive?**
The service was responsive.

People were supported by staff to take part in activities within the home and in the local community to promote social inclusion.

People's care and support needs were assessed, planned and evaluated. People's individual needs and wishes were documented clearly and met.

There was a system in place to receive and manage people's suggestions or complaints.

**Good**

**Is the service well-led?**
The service was well-led.

**Good**

# Summary of findings

There was a registered manager in place.

There was an open culture within the home. Staff were supported by the registered manager to provide care and support to people.

There was a quality monitoring process in place to identify any areas of improvement required within the home. However, some audits were not formally documented.

# Field House

**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 23 and 29 July 2015, was unannounced and was completed by one inspector, one inspection manager and an expert by experience. An expert by experience is someone who has experience of caring for or working with someone who has used this type of care service.

We looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also received feedback from representatives of the Cambridge and Peterborough clinical commissioning group and Peterborough City Council contracts monitoring team to aid with our inspection planning.

We observed how the staff interacted with people who lived in the home. We spoke with nine people (two by telephone), one relative and one visiting friend. We also spoke with the registered manager, head of care, administrator, three senior care workers, one care worker, one cook/carer, a visiting independent social worker, dietetic assistant practitioner and training assessor.

We looked at four people's care records and two staff files. We verified systems for monitoring staff supervisions and training. We checked other documentation such as quality monitoring records, fire safety records, staff meeting minutes, newsletters, menus, accident records, maintenance and utilities records, compliments and complaints, policies and procedures, and medicines administration records.

Requires improvement

# Is the service safe?

## Our findings

We received mixed feedback about the standard of cleanliness throughout the home. One person said, "My room is cleaned and I am happy with the job that is done." Yet one person told us that, "It [the home] should be like the City Hospital, clean and being cleaned regularly." A social care professional also expressed a concern about the cleanliness of a wheelchair they had been given to assist a person they were supporting on one occasion. Records clearly documented weekly cleaning tasks for staff to follow. However, our observations throughout the day showed that there were some areas of the home where the standard of cleanliness should be improved. For example we found a soiled modesty pad left for two hours which had not been disposed of correctly by staff in line with the provider's policy on infection control. We also saw that some other bathrooms and toilets and communal areas of the home were not clean. This meant that there was an increased risk of cross contamination and poor infection control.

People living in the home told us they felt safe and visiting relatives and friend agreed. One person said , "I like it here a lot. I am happy and safe here," and another person told us, "Yes I do feel safe and secure here." A relative confirmed, "I never have any doubts about the safety and comfort of my [family member] here."

People had detailed risk assessments within their care and support plans, which had been reviewed and updated on a regular basis. These documents gave clear information and guidance to staff about any risks identified and the support people needed in respect of these. Risks identified included people being at risk of falls, of falling out of bed, moving and handling risks, and poor skin integrity. Staff were aware of people's risk assessments and the actions to be taken to ensure that the risks to people were minimised. We saw that where people were at risk of developing pressure areas on their skin (poor skin integrity), appropriate equipment was available and used by staff to reduce this risk.

Policies and procedures in relation to the safeguarding of adults were available and contained relevant contact information. Staff told us that they had received information and training in relation to the protection of people they supported. They were able to demonstrate that they knew the different signs of abuse to look out for. Staff were also aware of the procedure to follow, and people to contact, if they thought people had been or were subject to potential harm due to poor care. The registered manger informed us, and training records confirmed that staff received regular training in respect of safeguarding adults.

Staff said that pre-employment safety checks were carried out on them prior to them starting work at the home. These checks included an application form, interview notes, photographic identification, professional references, and a disclosure and barring service check. This demonstrated that there was a system in place to make sure that staff were only employed if they were deemed safe and suitable to work with people who lived in the home.

Our observations showed that people were supported by staff with their medication in a patient, unhurried and safe manner. All staff who administered medication had received appropriate training and their competency was regularly assessed by the registered manager. The home had policies and procedures in respect of the safe handling, administration, recording, storage and disposal of medication and we saw that these had been followed. Records of medication administered were complete and we saw that all medication was stored securely and at the correct temperature. There were clear instructions for staff in respect of the administration of medication. This included medication that had to be administered at least 30 minutes before food. Information about when to administer 'as required medication' was also documented. The two senior care staff informed us that they had a good relationship with the local pharmacist, who provided advice when needed.

During our inspection we saw that there were sufficient staff on duty to ensure that people remained safe. One person told us, "They [staff] come in a decent time if I ring my buzzer." Another person said, "If I ring my buzzer they [staff] are usually there pretty quick." A relative confirmed that, "The staff undertake their responsibilities with care and diligence. It's never long between needing help and getting assistance." Our observations showed that people's needs were met in a timely manner and call bells were responded to promptly. We saw that staff had time to sit and talk with people in the home and provided care in an unhurried manner. Staff told us that there were enough staff in the home. They told us that if any member of staff was unwell, additional staff were called in to work at short

Requires improvement

# Is the service safe?

notice. One member of staff said, "It is really helpful to have a member of staff working from 11:00am until 15:00pm as we can be a bit rushed then and this really helps, it also means that we can do activities with people after lunch."

The registered manager and head of care told us that they spoke daily about the number of staff required to assist people with higher dependency support needs. This was confirmed by a staff member who told us that they were moved about to cover any shortfalls in staffing levels. The registered manager said that they would change staffing levels in line with people's dependency levels. However, they confirmed that this decision making process was not documented.

People had individual personal emergency evacuation plans in place and there was an overall business contingency plan in case of an emergency. This document gave details of emergency contacts and their details. This showed us that there was a plan in place to assist people to be evacuated safely in the event of an emergency.

We looked at the records for checks on the home's utility systems and the buildings fire risk assessment. These showed us that the registered manager made regular checks to ensure people were, as far as practicable, safely cared for in a place that was safe to live, visit or work in.

Requires improvement

# Is the service effective?

## Our findings

People had mixed comments about the meals provided. One person told us, "I like the food it is very nice," and another person said, "I like everything here. I like the food today, it is very good." However, five other people including a relative and visiting friend had less than positive feedback about the food provided. For example one person told us, "We get a banana snack or something in the morning and you can have a biscuit instead. That's the last of anything you'll see of anything fresh. It's the monotony of the food….it's mash, mash and then mash…the mashed potatoes are lumpy and often watery….the breakfast porridge is no better. The tea time is pretty bad. We might get jam or marmalade sandwiches…..I stock up with biscuits in my room. [Family member] also brings in fresh fruit." Another person told us, "I don't really want to complain about the food, but it could be more interesting with more change. I would love some pasta dishes a bit more." A relative told us, "The food isn't great and I think the quality of cooking and content could be improved." This feedback demonstrated that people thought the quality of the food they were being provided was variable. The cook told us that if people did not want to eat the hot menu choice on offer they could have sandwiches, toast or a fried egg instead. We saw that people did deviate from the menu, as a person was observed eating sandwiches at lunchtime instead of the hot meal option. One person told us, "At my last home, we had a choice and that makes mealtimes something to look forward to." However, our observations and from looking at the homes menus, we saw that people had a limited choice if they chose to deviate from the set menu on offer.

An assistant dietetic practitioner said that staff had referred anyone in the home who was identified at being at 'high' risk of malnutrition to them. Records were kept to monitor people's weight loss and the assistant dietetic practitioner confirmed that these records were good. They said that staff were very proactive in seeking guidance for people they felt were at risk, "Communication is good, they [staff] follow advice and guidance."

During this inspection we saw that people were offered drinks by staff throughout the day. We saw soft drinks on offer in communal areas of the home. People who required additional assistance with their food were supported by staff in a kind and respectful way. Where people required their food and fluid to be monitored, records were completed by staff. One staff member told us about the nutrition training they had completed. They said, "It really helped me to know about soft diets and what foods to give people when they were not eating very well." Our lunchtime observations showed that people were not always encouraged by staff to sit at the dining tables to eat their lunch. In the downstairs communal dining room only four out of 12 people eating their lunch were sat at the table. We noted that the meal was not very hot, the tables were not dressed with table mats and cutlery and condiments were not available for people. This meant that there was a missed opportunity by the staff to make meal times a more pleasurable experience for people and to promote social inclusion.

We spoke with the registered manager about the Mental Capacity Act 2005 (MCA) and changes to guidance regarding the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions. Assessments to establish people's capacity to make day to day decisions had been determined and appropriate applications made to the supervisory body (local authority). Records we looked at showed that staff had received training on MCA and DoLS. However, on speaking to staff they were unable to demonstrate their understanding of the requirements of the MCA 2005.

We saw that staff respected people's right to make their own choices in relation to their daily living. Staff demonstrated their understanding of why it was important to value people's preferences and how they respected people's choices. Most people told us, and our observations, confirmed this to be the case. One person said, "Everyone is nice to me, they [staff] know what I want." Another person told us, "I find that most [staff] ask permission before they do anything for me, but that's not always the case, maybe they are in a rush." Our observations showed that staff respected people's choices when assisting them with their personal care and daily living support.

Staff were knowledgeable about people's individual support and care needs. Staff told us about the training they had completed to make sure that they had the skills to provide the individual care and support people needed. This was confirmed by the registered manager's record of

Requires improvement

# Is the service effective?

staff training undertaken to date. During the inspection we met with an external training assessor who was supporting a staff member to develop their skills by completing a national vocational qualification. This showed that staff were supported by the registered manager to provide effective care and support with regular training and personal development.

Staff confirmed that they were supported with regular supervisions and that these supervision sessions were recorded. One staff member told us, "The manager is always in the home and is available to give us any advice that we need. We don't have to wait for supervision to discuss any concerns." Staff said that when 'new' they were supported with an induction process. This included 'shadowing' a more experienced member of staff. One staff member said, "My induction was very good, I did not have to do anything on my own until I was ready. I had lots of training during my induction and this really helped me to know how to look after our residents." This meant that staff were supported during their induction until they were deemed competent and confident by the registered manager and able to provide effective and safe care and support to people.

Staff told us that people had access to regular external health care when required. One person said, "They've called the doctor out for me when I didn't feel well." Staff informed us that the doctor visited the home each week and more frequently when required. Appropriate referrals had been made to health care professionals, their advice had been followed and detailed records of the health care provided had been maintained. Where people had an increased risk of falls, they had been referred by staff to the local falls team. This showed that staff sought external health care guidance when necessary.

Requires improvement

# Is the service caring?

## Our findings

Staff provided support to people in a kind and caring manner. They spoke with people gently and where people required assistance this was not rushed. A staff member said, "I love spending time and helping the residents, that it's what my job is about." We saw that people were spoken to in a respectful manner, and that staff called them by their preferred name, and knocked and waited for response before entering people's bedrooms. Doors were also closed when personal care support was being provided. However, one staff member we spoke with referred to the people they supported as being, "Like caring for small kids," which was an undignified way to describe an adult. During lunchtime observations we saw food and drink served on plastic plates and in plastic tumblers. We also saw that people's dignity was compromised by information that was displayed on walls in a number of people's bedrooms. This information was guidance for staff in relation to the day that people's bedding was to be changed, and on one bedroom wall there was guidance for staff about the time that the person needed to be taken to the lounge. This guidance needed to be readily available for staff, but in a format that did not undermine people's right to dignity.

People who lived in the home made positive comments about the care and support provided by staff at the home. One person told us, "They [staff] look after me well. I like it here." Another person said, "The carers [staff] are really kind and gentle. They speak in a nice soothing way and they are there for me." A relative told us, "It is not easy leaving someone you love in somebody else's hands so it is reassuring to know that the staff really care about my [family member]."

We saw that people's relatives and friends were able to visit the home whenever they wished and that they were made to feel welcome. One person told us, "Visitors can come when they like." One friend who was visiting said, "Visitors can come and go as they please." We saw that some relatives visited each day to help assist their family member to eat their meals. This meant that people were supported to maintain contact with people and family members who were important to them.

We saw that staff gave people choices and respected the choices they made in a caring manner. People could choose when to get up and go to bed. What clothes they wanted to wear and what activities to take part in. One person said, "I can go to bed when I like, in fact I like staying up late but that's no problem to them." Our observations showed that staff respected people's wishes.

People had regular reviews of their needs and support, which meant their care and wellbeing, was provided by staff who had the most up to date information. Records showed that people or their appropriate next of kin/legal representatives were involved in people's care and support plans. One relative confirmed, "The staff know my [family member] well and as far as I know I can see that they keep records which ensure that [they] are cared for appropriately."

In the care records we saw that people's end of life wishes were documented. This included legal paperwork which documented a person's wishes not to be resuscitated. We noted that one 'do not attempt resuscitation' document had not been completed in full, but had been signed as completed. We brought this concern to the attention of the registered manager during this inspection.

The registered manager showed us that information regarding advocacy services was made available for people if they wished to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

# Is the service responsive?

## Our findings

We saw people pursuing their interests and that their links with the community were maintained during this inspection. Examples included attending local religious services and visits to the shops. Staff also told us that religious services were also held in the home. We saw photographic evidence of a visit to the home by local school children who spent their time chatting to people. A new activities co-ordinator was about to start work within the home to offer more activities for people. Staff confirmed that activities occurred on a daily basis. We saw people supported to feed the fish, play board and card games and a musical event took place which was well attended. One person told us, "I can go out in the garden when I like and so I often sit near the fish pond. I've been out in the village with one of the carers [staff] it gives me a real feeling of freedom to be able to go out." However another person told us, "There's not a lot going on. We sing songs a bit. That's about it."

People's care and support needs were assessed, planned and evaluated to agree their individual and personalised plan of care and support. Records we looked at documented that people had signed to agree their plan of care and support. Reviews were carried out each month or sooner if required to ensure that people's current support and care needs were documented. Records included information on people's social history and any interests they may have documented in a 'my life past and present' form. This information helped staff to get to know and understand the individual they were supporting. Staff demonstrated a good understanding of each individual persons care and support needs.

We asked staff what action they would take if they had a concern raised with them. They confirmed to us that they knew the process for reporting concerns and that they would raise these concerns with the registered manager. Information on how to make a complaint was displayed on the communal notice board within reception and within the service user guide for people to refer to if needed. A relative told us, "Although I have had no cause to complain, I feel it is the sort of place where I would be listened to." However, one person said, "They wouldn't take any notice of me if I grumbled but I don't anyway." Records showed that only one complaint about the service had been received in the last twelve months, this had been thoroughly investigated and responded to in accordance with the complaints policy.

Good

# Is the service well-led?

## Our findings

The home had a registered manager in place who was supported by a team of care and non-care staff. We saw that people who lived at the home interacted well with the staff. People had mainly positive comments to make about the staff and registered manager. One person said, “The lady who runs the place is very kind and talks to me.” A relative told us, “The manager is friendly and you can talk to her easily.”

The registered manager said there was on-going quality monitoring process with actions taken on any improvements needed. Monitoring included, but was not limited to, medicine records, risk assessments, eating and drinking plans and people’s weight charts. However, these reviews although documented did not always have an action plan in place to provide robust written evidence of any actions taken.

People and their relatives were given the opportunity to feedback on the quality of the service provided. The registered manager said that information from the feedback was used to improve the quality of service where possible. The feedback showed positive comments about the quality of the service provided with some areas of improvement suggested. We saw documented actions taken as a result of feedback that required improvement.

Staff were aware of the whistleblowing procedures. They felt confident that they could raise any concerns with management staff regarding any poor care practice that they had witnessed or were concerned about. This showed us that they understood their roles and responsibilities to the people who lived in the home.

Staff told us that an open culture existed and they were free to make suggestions, raise concerns, drive improvement and that the registered manager was supportive to them. They said that the registered manager was very approachable and that they were available to discuss any concerns or answer any questions.

Staff confirmed that there were regular staff meetings to provide an open forum where they could raise topics they wished to discuss. Meeting minutes showed that the registered manager used these meetings to update staff on any suggested areas, such as improvements required in the laundry and better communication with relatives.

We spoke with the registered manager and administrator about notifications which they are legally obliged to inform us about. The management team were able to demonstrate that they were aware of the incidents in which the Care Quality Commission were required to be informed about. This showed us that the registered manager had an understanding of their role and responsibilities.