Farrington Care Homes Limited

Field House

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Field House is a residential care home personal care to up to 28 people. The service provides support to older adults. At the time of our inspection there were 23 people using the service with a further one person in hospital. The care home accommodated people across three separate floors in one adapted building.

People's experience of using this service and what we found
People were not protected from the risk of abuse. People 's medicines were not administered safely, and people were at risk of being over medicated. Risks to people were not always adequately assessed and recorded. Staff recruitment records were not always complete. People were not always adequately protected from the risk of infection. Lessons were not always learned following incidents.

Staff had not received up to date training. People did not always have their full needs assessed, but relatives told us people were offered choice. Some people were deprived of their liberty without authorisation from the local authority. Nutritional and hydration needs were not always adequately assessed and documented. Relatives told us there was a good standard of food choice.

There was a lack of oversight at the service from the registered manager and the provider. The service did not have a person-centred culture and the registered manager was not always accessible to relatives. People, relatives and staff were not engaged in the running of the service. The provider did not work well with partner agencies and this impacted on the care people received. People told us they felt safe at the service.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was good (published 27 September 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the service's response to deterioration in people's health and concerns raised by the local authority safeguarding team around care planning and incident reporting.

As a result, a decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led. However, following concerns found around Deprivation of Liberty Safeguards (DoLS), the inspection was also opened to the key question of effective.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken some actions to mitigate these risks, but this was not always effective.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Field House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safety, staff training, management and leadership at this inspection.

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 work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Field House

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Field House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Field House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

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. We also used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
As part of this inspection, we spoke with the Nominated Individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to two directors, the operations manager, the registered manager, six members of care staff, including a member of the housekeeping team. We spoke with three people using the service and the relatives of 11 people. The local authority also visited the service and shared feedback on their observations of the service during the inspection period.

We reviewed a range of written records including six people's care plans, staff recruitment and training records and information relating to the auditing and monitoring of service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse. We found several recorded incidents of alleged physical and sexual abuse which had not been reported to the local authority safeguarding team by either staff or the registered manager. These incidents were consequently not investigated at the time.
- The provider also failed to take appropriate actions to protect people following recorded incidents of abuse. One person was recorded to have physically assaulted people, relatives or staff on at least eight occasions, but no actions were taken to support this person and protect others.
- The provider failed to follow up safeguarding concerns raised by staff. A staff member told us they were concerned about the conduct of another staff member at the service and it was putting people at risk of harm. The staff member stated they had raised this to the provider, but there was not documented evidence of this being investigated or acted upon in safeguarding records.

Systems were not in place to protect people from the risk of abuse. This was a breach of regulation 13 (1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider made referrals to the safeguarding authority about recorded incidents of alleged abuse found by inspectors. Actions were also taken to reduce the risk of abuse and harm at the service.

Using medicines safely

- Medicines were not safely managed.
- People were at risk of overly restrictive medicine administration practices as well as not receiving medicines when needed. Several people frequently received 'when needed' prescribed sedatives without any documented reasons. Further to this, people did not have detailed 'when needed' protocols in place to inform staff when to administer medicines, such as sedatives. We also found two people did not have any protocols in place.
- Medicines trained staff were not part of the night-time rota, which meant people did not have immediate access to medicines if needed at night. We saw daily care notes which described one person had been in pain during the early morning, but they were not able to access pain relief medicines until the registered manager arrived hours later.
- People were not always supported to take medicines as prescribed. One person was observed to be administered a medicine with their breakfast, when the medicine administration record stated this medicine should be taken half an hour before any other food or drink was consumed.
- Medicines were not always stored safely. We observed loose returns medicines stored in the returns box. There was no information to advise where these medicines had come from.

Assessing risk, safety monitoring and management

● People's health deterioration was not always monitored safely. One person who had presented with pain for a prolonged period was not supported by staff to have their health observations taken despite equipment being in place for this. The person subsequently was taken to hospital when their condition deteriorated further.

● Risks to people's health, safety and welfare were not always identified or managed effectively. People's care plans and risk assessments were not always in place in a timely manner. One person had been at the service for five days. There were known risks on admission. However, no risk assessments had been completed. This means that staff could not manage the risks to this person and meet their needs.

● Several people with known risks did not have specific risk assessments or support plans in place to inform safe care. For example, one person was known to present with a sexual safety risk but did not have risk assessments in place to help inform staff how best to support this individual and protect others.

Preventing and controlling infection

● Safe IPC (infection prevention and control) practices were not always followed.

● Staff did not always wear PPE (personal protective equipment) safely. Across two visits to the service, we saw staff members not wearing face masks.

● Staff did not always follow government guidance for professional visits to the service. Across two site visits, inspectors were not asked to present COVID-19 lateral flow test results on entry to the service.

● We were not assured that cleaning was taking place to reduce the risk of infection. Night staff did not complete a night-time cleaning checklist and there was no other evidence of this cleaning taking place. The registered manager told us this was because staff had said they did not have time to do this.

● Relatives' views on the cleanliness of the service were mixed. Some relatives felt the service was very clean, while others felt it was dated and often dirty. There were also concerns raised that the service often smelt of urine.

Systems were not in place to assess, monitor and mitigate risks related to people's care and support needs, medicines management and infection, prevention and control. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following conversations with inspectors, the operations manager and staff team took action to reduce identified risks around medicines administration. This included adding more information to 'when needed' protocols, ensuring medicines trained staff were present at night and arranging medicines reviews for people with the GP.

● People we spoke to said they felt safe at the service.

● Relatives did not raise any concerns about restrictions on visiting the service.

Staffing and recruitment

● Evidence of safe recruitment was not always in place. While staff records we reviewed included DBS (Disclosure and Barring Service) checks before commencing employment at the service, staff recruitment files were not always complete. For example, two staff members' recruitment files failed to include records of references received and had unexplained gaps in their employment history. This put people at risk of unsafe support.

DBS checks provide information including details about convictions and cautions held on the Police National Computer.

Accurate, complete and contemporaneous records were not always kept by the provider. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Insufficient numbers of trained and experienced staff were deployed at night to meet people's needs and keep them safe. At night, two staff members were on shift each night when four people needed two staff interventions which put people at risk of delayed support. There was no staffing dependency tool in place at the service, but the registered manager told us there was an informal on-call system in place, where night staff could call the registered manager or local staff to come and support when needed.
The provider had not ensured there were sufficient numbers of staff deployed to meet people's needs. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Relatives had mixed opinions on staffing levels. Some relatives told us staffing levels were too low. One relative said, "There are not enough staff all the time, [my relative] has accidents, four times I have been there and it's obvious they need cleaning up. I ask staff for help and it can be 20 minutes and it's still not done." Other relatives were more positive, one stated, "Yes, the house is secure and there are always lots of staff around."

Learning lessons when things go wrong
● Lessons were not learned following incidents.
● We found evidence of several recorded incidents, which failed to include follow-up actions and measures to mitigate further occurrence. For example, one person had sustained multiple falls since the beginning of the year, including falls on the stairs. There was no evidence that support was put in place to protect this person from the risk of re-occurrence.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not have up to date training in place. One staff member did not have any evidence of completing training since joining the service over six months ago. The registered manager told us the staff member had completed their training at a previous employer, and they were waiting to see the certificates. The registered manager had failed to evaluate any of the training the staff member said they had completed as part of the employment process.
- Staff had not received routine refreshers on their training. Staff files we reviewed showed staff had not received updates to their training in areas such as safeguarding and moving and handling. In some cases, no refresher training in these areas had taken place for almost three years. The registered manager told us this was because they could not book face to face training due to COVID-19 and that staff did not want to complete online training. This left people at risk of not receiving safe and effective care.

The provider had failed to ensure there were suitably trained staff employed to meet people's needs. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following discussions with inspectors, the provider had planned for staff to complete further training in areas such as medicines administration.
- Some relatives told us they were concerned that new staff had not received training. One relative stated, "What's become evident is that new staff are very poor or totally untrained."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not have full assessments of needs in place. As discussed in the safe section of this report, people did not always have care plans in place which accurately reflected their needs, such as one person who was receiving end of life care. This meant staff did not have access to information to inform safe decisions about people's care.
- Some people's care plans were not personalised and included generic information not specific to their needs.
- Relatives told us that staff supported people to have choice in their care and know the needs of people.

Supporting people to eat and drink enough to maintain a balanced diet

- Care plans lacked details about people's nutritional needs. For example, one person was noted that they required a soft diet but was observed to be eating a normal diet by inspectors. Staff stated that the soft diet

was not due to swallowing issues but due to lack of teeth. Their care plan failed to detail this. We also observed this person needing support to initiate eating their food, but their care plan stated they did not need any support with eating.

● People's nutritional needs were not always assessed when risks were present. One person who had previously been at risk of malnutrition had refused to be weighed since August 2020. No other method to monitor the person's weight or body mass index (BMI) had been used to support the person to maintain a healthy weight.

● Food and fluid charts were in place for some people, but these were not always completed correctly. Two people's fluid charts had the running totals of fluids consumed filled in incorrectly. This put people at risk of becoming dehydrated as it was not always clear how much people had consumed.

● Relatives were mostly positive about the food being served at the service. One relative said, "the food is excellent, some of the food they cook is amazing."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Health input was not always sought in a timely manner. People required specific health input, but this had not been sought by the staff team.

● Reviews from the GP, such as medicines reviews, were not always requested when needed to ensure the correct prescription was in place. Multiple people were receiving a high frequency of 'when needed' medicines but this was not referred to the GP.

● Relatives were not always satisfied with the support being provided by the service to access healthcare. One relative told us, "[My relative] wasn't well when he first went in, I asked for him to see a doctor and was told it takes 6 weeks to get a doctor in."

● We found evidence of the service having contact with other agencies such as community nurses. The registered manager told us that they worked closely with local GPs and nurses.

Adapting service, design, decoration to meet people's needs

● Areas of the building were dated and cluttered. For example, the conservatory roof was visibly dirty, and the sunshade was in a state of disrepair. The conservatory was also used to store games, wheelchairs and other moving and handling equipment. This presented as untidy and collected dust.

● People's rooms had some evidence of personalisation with photos and possessions. However, there were no signs to clearly show who lived in each room which would have supported people to find their own rooms if needed.

● Relatives told us there was inconsistent personalisation of people's rooms, with some being homely and some not at all.

● The service had a large garden and grounds for people to use in good weather. One relative said, "The garden is lovely, they keep the grounds very well."

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met

● We found the service was not working within the principles of the MCA and appropriate legal authorisations were not in place to deprive people of their liberty. There were several people at the service who presented as lacking mental capacity being deprived of their liberty but appropriate DoLS authorisations had not been sought for these people from the local authority.
● The registered manager did not have a good understanding of the DoLS process. The registered manager told us they only applied for DoLS authorisations for people who lacked mental capacity when they actively wanted to leave the service, which did not follow the MCA 2005 guidelines.

Systems were not in place to lawfully deprive people of their liberty. This was a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Inspectors raised concerns with the registered manager about people being deprived of their liberty unlawfully at the service during the inspection. Following this, the registered manager applied for DoLS authorisations for all people living at the service, but this included people who presented as having mental capacity to consent to living at the service, which again did not follow the MCA 2005.
● There was some evidence in people's care plans of mental capacity assessments, however some people did not have appropriate assessments or best interest (BI) decisions in place. For example, we saw one person had a BI decision for community nurses administering insulin but there was no evidence of a mental capacity assessment for this specific decision.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

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

- Robust quality assurance systems were not in place, putting people at risk of unsafe care. The registered manager had not completed several recent monthly quality assurance audits. For example, medicines administration and IPC had not been audited for two months at the time of the inspection. The registered manager told us this was due to internal pressures at the service increasing their workload.
- As outlined in the safe section of this report, there was no recent oversight of recent accidents and incidents to help protect people from re-occurrence. The registered manager, therefore, was unable to identify patterns in incidents to learn lessons and help protect people from avoidable harm.
- The provider did not have oversight of the actions of the registered manager or the level of care being provided by the service. The registered manager told us that the provider supported them with practical issues at the service such as the physical building rather than issues relating to the care being provided. There was no evidence of provider level audits or monitoring taking place.

Systems and processes were not established and operated effectively to ensure good governance. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had not received recent supervisions or appraisals of their performance from the registered manager or provider so areas of improvement in practice were not being highlighted. The registered manager stated supervisions had not been completed since October 2021 and senior staff were beginning to conduct supervisions at the time of the inspection.
- Processes were not in place for staff to be accountable for their decisions and record their actions. For example, as mentioned in the safe section of this report, administration of 'when needed' medicines did not have reasons for administration documented. The registered manager had failed to identify issues with staff recording and had not put processes in place to ensure justification for the administration of restrictive medicines
- The provider put a new system in place for the recording and analysis of accidents and incidents following concerns being highlighted by inspectors.
- Some quality assurance audits were completed, such as the IPC audit, by the provider following concerns being highlighted by inspectors.

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

● The service did not have a person-centred culture and terms used within the service were degrading. Staff and the registered manager were heard to use terms such as 'lazy' and 'terrorising' when describing behaviour of people at the service. On review of written behaviour charts for one person, a staff member had written 'because of their aggression and behaviour they will be staying in their room for the rest of the evening.'
● The service was not consistently well-led and the registered manager appeared out of touch with what was happening at the service. For example, as described in the safe section, when inspectors arrived at the service, one person was waiting to be taken to hospital. The registered manager, however, was not aware an ambulance had been called for this person when asked about it.
● Staff did not always have confidence in the management of the service. One staff member stated that they were made to feel guilty by the registered manager when booking annual leave and actions were not always taken when concerns about people or staff were raised.
● While some relatives felt the registered manager was approachable, others told us the registered manager's presence was not always evident at the service. One relative said, "It is noticeable that there is something not quite right, seeing the good staff plummeting in moral, and the residents are less settled. Staff are clearly not happy. Management are absent, there is no one to discuss anything with."

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
● As outlined in the safe section of this report, potential safeguarding concerns were not always dealt with in an open and objective way by the registered manager. Several incidents of abuse were not investigated or reported to the local authority safeguarding adults team, leaving people at risk of harm.
● Relatives gave mixed feedback on the communication they had with the registered manager. Some relatives told us the registered manager contacted them when needed. However, other relatives told us communication was poor. Speaking about the service coming out of a period of restricted visiting due to COVID-19, one relative told us, "It turns out they opened and didn't let us know. Communication is terrible, horrendous." Another relative said, "Communication is terrible. I wasn't told they had gone into lockdown and drove all the way there. I was very annoyed."
● There was little evidence of views being sought from people, staff or their relatives on the running of the service. Several relatives told us they had not been asked for formal feedback on the performance of the service.

Working in partnership with others
● There was little evidence of partnership working. As discussed in the safe and effective sections of this report, the provider failed to work with other agencies to provide the best support possible.

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 The provider failed to ensure risks associated with medicines administration and storage and Infection prevention and control were managed. Risks to people were not adequately assessed.

The enforcement action we took:

Warning Notice to be served.

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 The provider deprived people of their liberty without authorisation from the local authority. The provider did not protect people from abuse and safeguarding incidents were not reported and acted upon.

The enforcement action we took:

Warning Notice to be served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have sufficient oversight at the service. Contemporaneous records were not kept in relation to recruitment. Quality assurance audits had not been completed and this left people at risk of unsafe care. Where concerns were identified, these were not acted upon.

The enforcement action we took:

Warning Notice to be served.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The provider failed to ensure staff had received both appropriate and up to date training.

The enforcement action we took:

Warning Notice to be served.