Fieldside Care Limited

Fieldside Care Limited t/a Fieldside Care Home

Inspection report

9 Canadian Avenue
London
SE6 3AU

Tel: 02086901215
Website: www.parksidecare.org.uk

Date of inspection visit:
26 January 2021
16 February 2021

Date of publication:
19 April 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Fieldside Care Home provides care and accommodation for up to 34 older people, some people living with dementia. At the time of our inspection there were 30 people receiving care and support.

People's experience of using this service
People were not always safe. The provider had not ensured risks to people were always documented and mitigated. Risk assessments and care plans contained conflicting information which could potentially lead to people being exposed to harm.
Quality assurance processes were not always effective in identifying and addressing the shortfalls in care plans and risk assessments we found. We discussed our concerns with risk management and quality assurance systems with the registered manager and nominated individual during the inspection and they have taken action to resolve some of the immediate issues we identified.

People's medicines were managed safely by trained staff. The provider had responded to the risks associated with the Covid-19 pandemic. Infection control procedures had been increased in line with current guidelines to reduce the risk of infections being brought into the service. There were regular audits and maintenance checks to ensure safety issues were resolved and hygiene levels were maintained.

We received positive feedback from people about the care they received and the management of the service. People told us staff were kind and caring and the service was a pleasant place to live. Staff were positive about how the provider had supported them during the pandemic. The provider worked in partnership with a range of health and social care professionals.

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
At the last inspection, the service was rated as requires Good (Report published 25 June 2019). The rating has deteriorated to requires improvement.

Why we inspected
We undertook this focused inspection to follow-up on specific concerns that we received about the risk management processes within the service. A decision was made to examine those risks. During the inspection we widened the scope to include the key questions of safe and well-led. No areas of concern were identified in the other key questions. We therefore did not inspect them.

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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. The provider had taken some action during the inspection to mitigate risks and continued to liaise with the inspector after the inspection to advise of further improvements scheduled.

Enforcement:
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 have identified breaches in relation to risk assessments and quality assurance processes 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. If we receive any concerning information we may return to inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

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

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
The inspection was carried out by one inspector.

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

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave the provider 48 hours' notice of the inspection. This was because of the COVID-19 pandemic. We wanted to check if anyone was displaying any symptoms of the virus and to be aware of the provider's infection control procedures.

What we did before the inspection
We looked at information we held about the service. This included details about incidents the provider must notify us about, such as allegations of abuse and serious accidents and incidents. We also reviewed all other information sent to us from other stakeholders, for example the local authority and members of the public.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who were receiving care and made observations of people's support and interactions with care workers to help us understand their experience. _We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service. We reviewed five people's care and medicine records. We looked at two staff files in relation to recruitment and supervision. We also looked at policies and procedures and records related to the management of the service and infection control.

After the inspection
We received feedback from five relatives of people who used the service. We also made calls to three people receiving care, four care workers, the deputy manager and an administrator. We continued to seek clarification from the provider to validate evidence found in relation to people's care and support, staff training and quality assurance processes. We also sought feedback from professionals with knowledge of the service.

Requires Improvement

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 Good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● The provider used a wide range of risk assessment tools to consider the risks associated with people's health and social care needs. However, we found information about individual risk factors in care plans and risk assessments was conflicting. For example, one person who was being treated for an ongoing pressure ulcer had conflicting information recorded in different parts of their care plan. This meant the guidance for staff was not clear on what actions were needed daily to reduce the risks.

● The risk of fire had been assessed and individual personal emergency evacuation plans (PEEPs) were in place. However, several of the PEEPs contained inaccurate statements about people's ability to evacuate safely. The PEEPs also did not correspond with the overall evacuation plan for the service so there was a risk staff would not know what to do in the event of an emergency.

● Staff members told us that one person was at risk of choking due to behaviours of putting objects in their mouth. This risk was not clearly documented in their care plan or risk assessments so there was a risk not all staff would be aware of this behaviour and take the necessary action to reduce the risks. We discussed the lack of risk assessment for this established risk and the registered manager has taken action and put a risk assessment in place which explains what staff should do to mitigate the risk of harm.

We found no evidence that people had been harmed however, systems were not robust to ensure risks were effectively mitigated. The failure to effectively mitigate risks to people's health and wellbeing was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People receiving care and their relatives were positive about how the staff kept them safe. We received comments such as, "I have no doubts they are keeping [family member] safe" and "I am entirely confident [family member] is safe. I have always observed attentive staff and [family member] has the capacity to say if she feels uncomfortable or worried about her safety."

● There were regular safety checks of the service to ensure hazards and maintenance issues were identified and actions taken to remedy these.

Staffing and recruitment

● The provider did not have a systematic way of reviewing and assessing staffing levels based on people's dependency and care needs. Staffing levels also did not correspond with the level of support stipulated in people's personal evacuation plans as several plans we reviewed stated people would need support of one staff to remain in their room in the event of an emergency. The staffing levels of two staff during the night would make this level of support impossible.

● We did not identify any concerns with current staffing levels and people receiving care and care workers all confirmed there were enough staff on duty to meet people's needs safely. One member of staff told us "Oh yes there is enough of us to see to everyone and make sure we don't miss anything." The lack of a dependency tool or any other systematic process of assessing staffing levels meant there was a risk that current staffing levels would not be sufficient if people became more dependent or developed more complex care needs.

We recommend the provider reviews the process for assessing staffing levels in light of people's dependency and ensures there are sufficient staff to manage people's personal evacuation plans.

● The service followed safe recruitment processes. There was a system in place to ensure that all pre-employment checks were completed before staff started work. Checks included people's right to work in the UK, employment history, references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Learning Lessons when things go wrong
● There was a system in place to record accidents and incidents when they occurred however, the system was not always effective as not all accidents and incidents had not been reviewed and analysed by the registered manager.
●The registered manager and falls champion reviewed and analysed falls to ensure necessary action was taken when people sustained a fall. However, we observed that one person had sustained a minor injury due to a fall which was not recorded in the falls log we reviewed. The failure to record and analyse all accidents and incidents meant patterns and themes could not be identified and lessons were not learnt to ensure improvements were made to reduce the risks.

Preventing and controlling infection
● The provider had reviewed their infection and prevention control policy during the COVID-19 pandemic and staff were kept updated with changes to government guidance to ensure risks to people, staff and visitors were reduced.
● The provider was preventing visitors from catching and spreading infections as visits were currently restricted with detailed visiting protocols in place. These included temperature checks, a questionnaire to complete and the provision of hand sanitiser and personal protective equipment (PPE) for visitors upon entry. Family members told us, "Fieldside have kept residents' families advised throughout the pandemic and its changing restrictions as they are lifted or further imposed."
● Staff had completed infection prevention control training and were observed to be wearing the correct PPE. Staff were aware of how to put on and take off their PPE and disposed of it safely in line with recommended guidance.
● Staff were extremely positive about the support they received from senior managers during this period and told us they always had enough PPE, even during the peak of the pandemic. One staff told us, "We have been given extra uniforms and there are always plenty of masks and gloves."
● We observed the home to be clean and free from malodours and there was a written record of the current cleaning schedule. We shared guidance related to cleaning products with the registered manager after the inspection.

Using medicines safely
● Medicines were managed safely by trained staff who had been assessed as being competent.
● The registered manager regularly checked people's medicines and promptly investigated any issues.

Samples of medicine administration records (MARs) we reviewed had been completed correctly and we could see there were processes in place to ensure medicines were being stored at the correct temperature.
● The service was supported with medicines management by a local pharmacy service which reviewed people's medicine care needs, supported staff to ensure systems and processes continued to meet current guidance and provided ongoing advice and training. The pharmacy service was positive about how the service managed medicines. They told us, "The staff at Fieldside are often proactive in contacting us to consult with queries on medication matters that they are unsure of. We produce various supporting guidance which Fieldside have had good uptake and use effectively."

Systems and processes to safeguard people from the risk of abuse
● Staff had a good understanding of safeguarding procedures. They knew who to inform if they had any concerns about abuse or safety and how to escalate their concerns if they were not satisfied their concerns were being taken seriously.
● The registered manager was aware of their responsibility to report safeguarding concerns to relevant organisations including the local authority and CQC.

Requires Improvement

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 Good. At this inspection, this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Quality assurance systems were not always effective in identifying and addressing shortfalls in quality and safety. Care plans and risk assessments were routinely audited for quality and accuracy, but the audits had not identified the inconsistencies across the care plans and risk assessments that we found.
- The process for monitoring accident and incidents was not effective in identifying trends and themes and ensure lessons were learnt when things went wrong. Not all accidents and incidents had been recorded according to the provider's policy.
- The provider usually sent the appropriate notifications. However, we identified one example where the provider had failed to notify us when someone developed a serious pressure ulcer injury.
- The service did not do all that they could to meet people's equality characteristics. Care plans contained some confusing and misleading statements about people's sexuality needs. We asked the registered manager how they ensured they met the needs of LGBT people who used the service but there was no consistent way of assessing people's equality needs.

The provider failed to ensure systems and processes were in place to effectively assess, monitor the quality and safety of the service and ensure people's equality needs were met. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was meeting their responsibility to display the ratings of the previous inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives of people using the service were positive about how well the provider communicated with them, especially around the changes that had been put in place in response to the COVID-19 pandemic. We received comments such as, "The [nominated individual] and the [registered] manager are both very approachable and hands-on. They know what's going on and will take time to talk to you when you visit" and "They send a newsletter each month with updates about what's going on. We also have a whatsapp group which is really useful."
- The registered manager arranged regular staff meetings to discuss the quality of the service, plan improvements and to keep all staff informed of relevant information.
- Staff were positive about the service being delivered and the support they received from the provider. We received comments such as, "The managers are very good and very approachable, they help us a lot. If there is anything we are concerned about with a resident they always listen and resolve things straight away" and "I love my job. We are like a family here; the atmosphere is lovely. It really makes you want to come to work."

● There were regular residents' meetings to discuss a range of ongoing topics such as; the running of the home, activities, health and safety, the Covid-19 pandemic and the measures that were in place to reduce the risks.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● People receiving care and their relatives were confident in the way the manager led the team to ensure they received high-quality care and support. We received comments such as, "Fieldside has a wonderful, caring team provided by [the nominated individual] and [the registered manager]. All the staff are friendly and caring. We are so grateful that [family member] has a place there" and "I couldn't sing their praises more highly. They didn't know [family member] before but they have been made [family member] so welcome straight away. They really do care and they always contact me if they have any concerns."

● There was a clear handover procedure between each shift which covered areas such as medicines, health updates, infection control and any other significant information such as appointments and activities.

● The service continued to understand their responsibility to be open and honest and give all relevant people information when things go wrong. One relative told us, "They always inform us of anything significant that has happened."

Working in partnership with others

● The service regularly worked in partnership with other health and social care professionals to ensure people received ongoing support to meet their needs. We received positive comments from professionals about how the service worked in partnership with them to plan and deliver care and support. One professional told us, "The staff are very engaged and endeavour to work and support their residents, offering person centred care and are prepared to work well in partnership to achieve this."

● The service worked in partnership with the GP to ensure people's health needs were met. The GP told us, "We have worked with Fieldside for many years and the reason we stay as medical advisers without a private contract is because they are one home who we feel care for their patients very well. Their staff are very caring, and this is due to the example and lead from the top. Leadership is very accessible and from what I can see leads by example.

● The provider was engaging in the NHS led 'Coordinate My Care' programme which is a way of capturing people's medical care needs so that key information is easily accessible to all care services when people required urgent medical care.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was practicable to ensure that care and treatment was provided in a safe way as risks to people were not always identified and mitigated. Regulation 12(1)(2)(a), (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service effectively. The provider had failed to ensure people received a consistently safe service. Regulation 17 (1) (2) (a) (b) (c) (f)