RBL Field House Care Ltd

Field House Residential Care Home for the Elderly

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Field House Residential Care Home for the Elderly (Field House) is a residential care home providing personal and nursing care to 43 people aged 65 and over at the time of the inspection. The service can support up to 49 people.

The care home accommodates 49 people in one adapted building. Each of the two floors has a number of bedrooms and shared areas such as lounges and dining rooms.

People's experience of using this service and what we found
The service was not well-led and the provider had not had sufficient oversight of the service to ensure a high quality, safe service was provided to people. Monitoring of the service had not identified the shortfalls we found.

There were not enough staff deployed, with the necessary skills, training and knowledge to provide people with safe, high quality, compassionate care. Not all staff understood how to keep people safe from avoidable harm and abuse. The provider had not taken all reasonable steps to protect people from the spread of infection.

Staff did not always treat people with dignity and respect, support people to be independent or respect people's privacy. Care plans were not fully person-centred and people did not have sufficient opportunities to be involved in meaningful activity.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Medicines were managed well and were given to people safely. Some staff were kind and compassionate. The local authority officers were encouraged that the provider and registered manager were willing to work with them to improve the service.

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

Rating at last inspection
This service was registered with us on 25 July 2019 and this is the first ratings inspection. The last rating for the service under the previous provider was good, published on 7 July 2017.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, safety, care and management of the service. A decision was made for us to inspect and examine those risks. We inspected all five key

questions so that we could rate the service under the new provider.

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 a number of the concerns raised by the whistle-blowers were justified and the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, infection prevention and control, staffing, dignity and respect, person-centred care and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Field House Residential Care Home for the Elderly

Detailed findings

Background to this inspection

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

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 three inspectors and an Expert by Experience (ExE). An ExE has personal experience of using or caring for someone who uses this type of care service. Two inspectors carried out the visit to the home on 12 May 2021. The ExE spoke with people and relatives of people living in the home. The third inspector spoke with staff, analysed information and gave feedback to the registered manager and the nominated individual: the nominated individual is responsible for supervising the management of the service on behalf of the provider. The inspection was completed on 16 June 2021.

Service and service type
Field House 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 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
This inspection was unannounced.

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

During the inspection
On the day we visited Field House we met a number of people who lived there and saw how they interacted with each other and with staff. We spoke over the telephone with two people about
their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, senior care workers, care workers, including agency care workers, and the administrator. We also spoke with five relatives of people who live at Field House. Their contact with the home and their family members had been very limited, due to government COVID-19 guidelines preventing visits.

We reviewed a range of records. This included care records and medication records. We looked at two staff files in relation to recruitment and staff supervision as well as a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection (under the previous provider) this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● There were not enough staff deployed, with sufficient skills, experience and knowledge to meet people's needs and keep them safe. On the day we visited, staff on duty were not deployed well. On the upper floor there were four staff on duty: two agency staff were working together so did not have the guidance of permanent staff. Staff reported that eight people needed the assistance of two staff for transferring and personal care. They said when two of these people were being assisted, there were no staff available to supervise or assist other people. Following receipt of the draft report, the provider told us, "Two of the agency staff have been at Field House on at least 12 previous occasions."

● People and one relative told us there were not enough staff. One person said, "Staff don't sit and chat to me…they are too busy and there are not enough staff around anyway." Another person said, "There are not enough staff…sometimes it's been up to two weeks before I get a shower." Staff said there were not enough staff, which meant that at times call bells rang for a considerable length of time, so people did not get assistance when they needed it. During a lunchtime observation by the local authority, two people who needed staff assistance were still sitting at the table waiting for their meal for 40 to 45 minutes after other people had finished eating their main course.

● During our visit we noted there were no staff in the lounge where people living with dementia spent their day, for long periods of time. During one period of 25 minutes, one person, assessed as not safe to stand alone, was standing up and calling for help. Another person was shouting out and hitting themself. Records showed that a number of people had had unwitnessed falls. The local authority continued to have concerns about the number of staff on duty following our site visit.

● Prior to the inspection we had received information that there were not enough staff at night. The registered manager told us that some nights there were not enough suitably trained and experienced staff. They had employed agency staff to cover the shifts but there had not always been a senior member of staff on duty. This meant there were no senior staff at the home to advise and lead the care staff and no staff trained to give people medicines if they needed them. An on-call manager had to go to the home if medicines were required.

● The provider did not use a formal dependency tool to help calculate the number of staff required to meet people's assessed needs. The registered manager told us, "We don't use a specific tool, we look at how many people need how much support."

● The provider had attempted to recruit staff, but this had not been very successful. One person said, "Some young girls come and then go, because they don't like the work or want the job." The provider employed a lot of agency staff, some of whom did not always demonstrate that they had the training, skills or commitment to provide a good service to people living at Field House.

The provider had failed to deploy a sufficient number of staff who had the necessary skills, experience and knowledge to enable them to carry out the duties they were required to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a recruitment process in place but this had not always been followed well enough to make sure that new staff were suitable to be employed at the home. The provider had carried out identity checks and a criminal record check through the disclosure and barring service (DBS) and staff confirmed they had waited for all the checks to be obtained before they could start work. However, all three staff files we checked had gaps in the records. For example, there was not always evidence that previous employers had been contacted; references were not always from previous employers, gave little information and had not been verified; and gaps in employment histories had not been explained.

Systems and processes to safeguard people from the risk of abuse
● People were placed at risk of harm because the provider did not have a system in place that was robust enough to ensure people were protected from abuse or avoidable harm. During our inspection we found and witnessed incidents of potential harm or abuse: we made five safeguarding referrals to the local authority. Records showed that safeguarding referrals had not always been raised in a timely manner.
● The training staff had undertaken had not made all staff fully aware of what 'abuse' meant, how they should behave with people and what they should report. Staff we spoke with did not all know the meaning of safeguarding and were not all aware of their responsibilities to ensure incidents were reported and dealt with appropriately. Some staff told us they would report any concerns to the senior member of staff on duty. They were not all aware that they should report outside the service, for example to the local authority, if no action was taken.
● The provider and management team had not always referred safeguarding incidents to the local authority in a timely manner and they had not always notified CQC. For example, on the day of the inspection we noted that one person had a badly bruised hand. We were told this had happened two nights previously and an X-ray had confirmed broken fingers. This had not been reported to safeguarding nor to CQC. A relative told us, "Safe to a certain extent…but the home does not have enough staff to support my [family member] safely." They told us their family member had fallen the previous day, was found unconscious and taken to hospital.

People were at risk of abuse and avoidable harm as the provider did not have a robust system in place to protect them. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person told us they felt safe. They said, "Yes I always feel safe living here. I think it's the carers who help me keep safe. They keep me independent." Relatives had mixed views. One relative said, "Definitely my [family member] feels safe as her health has improved physically."
● An easy-read document was on display in the hall, outlining the safeguarding policy.

Preventing and controlling infection
● We were not fully assured that the provider's infection prevention and control procedures and policies were practiced robustly enough to ensure people and staff were protected from COVID-19. For example, during our inspection a member of staff removed an apron from one person and put it on another person without cleaning or sanitizing it. Staff did not support people to follow social distancing guidelines. People in the lounge area were seated in chairs next to each other. At lunchtime staff assisted people to sit close to each other at the dining tables.
● During the second COVID-19 lockdown, one person regularly left the home to visit local shops and did not

follow the government's guidance on self-isolation on their return to the home. The provider had put a risk assessment in place to minimise the risks to the person leaving the home. But they had not identified the risks to the people living in the home and the staff each time this person returned.
● A healthcare professional carried out an IPC visit on 11 June 2021 and found a number of issues, especially relating to equipment and the environment. These included stained chairs and malodorous and torn floor coverings. The provider was working on addressing these issues, which, when completed, would reduce the risks of infections spreading.
● The registered manager told us they were starting to think about how they could address these issues, perhaps by swapping the lounge and dining areas and buying coffee tables to separate people's chairs. However, our visit took place almost 14 months after the first COVID-19 pandemic lockdown, so measures should have been put in place sooner.

The provider had not always taken all reasonable steps to minimise the risks of spreading infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had systems in place to enable people to have visits from some of their relatives in a safe way. All visitors to the home were tested for COVID-19 and provided with appropriate personal protective equipment (PPE) to keep them and their family members safe. People and their relatives were able to meet in the 'visiting pod' where they were separated by a screen, or in the garden.
● We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● The provider did not have a sufficiently robust system in place to learn lessons when things went wrong. There was no evidence of learning, such as from analysis of incidents and accidents, so that actions could be put in place to prevent recurrence. The registered manager said they held a de-brief session for staff if there was a sudden death.

Assessing risk, safety monitoring and management
● The provider had a risk assessment process in place. Staff had completed assessments of any potential risks to people as part of the care planning process. These included the risks for one person who went out alone to the shops. Guidance was available to staff as part of the risk assessment so that risks could be minimised.
● Fire safety measures were in place to ensure that people, staff and visitors to the home were safe. The registered manager said that staff undertook regular checks of all equipment and systems in the home, such as the fire alarms and emergency lighting. Each person had a personal emergency evacuation plan (PEEP) in place so that emergency services would know how to support them in the event of a fire.

Using medicines safely
● Following concerns about medicines management, a pharmacist from the local authority had been working with senior staff to improve the way medicines were dealt with. Staff had worked well with the pharmacist and we found that medicine management was satisfactory.
● Medicines were recorded, stored and disposed of properly. Records showed that medication administration record (MAR) charts were completed accurately and people told us they received their medicines at the right time. Staff carried out audits of medicines and took action if needed.
● There were protocols in place for medicines prescribed as 'when required'. Staff had recorded why the medicine was needed.

Requires Improvement

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 the last inspection (under the previous provider) 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.

Staff support: induction, training, skills and experience

- Staff did not always have the skills and knowledge to carry out their role. People told us some staff seemed to know how "to do the basics" but others didn't know very much. One person told us they thought "staff training is poor." One member of staff said they had not had any training in how to respond to someone whose behaviour was challenging the staff. A relative felt staff did not know how to meet the needs of people living with dementia, in particular the needs of their family member.
- Staff had undertaken a range of training courses. However, they had not all learnt from the training they undertook and had not always applied it to improve their practice. For example, they showed they did not understand their responsibilities regarding safeguarding people from abuse and avoidable harm; they did not always follow correct IPC procedures; and they had not received training in caring for people at the end of their life.

The provider had failed to deploy a sufficient number of staff who had the received adequate and suitable training to enable them to carry out the duties they were required to perform. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager said that, as well as one-to-one supervision every few months, they worked alongside staff to supervise and monitor their practice.

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

- The registered manager told us that they or the deputy manager would be carrying out assessments of people's needs to make sure that the service delivered by the staff would meet those needs.
- The provider told us that the management team kept staff up to date with good practice in a number of ways. These included an education notice board and on Whatsapp. They said recent topics included dementia, infection control, management of pressure sores and safeguarding.

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

- Staff did not always support people well enough to make sure they ate and drank enough. We received concerns that people were being 'force-fed'. We saw one person given far too much food on one spoonful, struggle to eat it and then refuse to eat any more f their main meal. The local authority's observation of a lunchtime meal raised a number of issues, including one person in their room being left with food that was out of reach, and one person only being assisted when their food was cold.

● People told us they always had two choices for their main meal and described the food as "alright". Relatives were satisfied with the food their family members were given and commented that there were always plenty of drinks available.

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

● During the pandemic senior staff had taken on some of the tasks normally carried out by the district nurses, such as insulin injections, and any contact with the GP had been via telephone or video calls. This meant there had been less opportunity for staff to work with other healthcare agencies, but people's basic healthcare needs had been met.

● The local authority reported the staff at the home had worked well with them in order to improve the service provided to people who lived there.

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

● Field House was a residential property that had been extended a number of times over the years to increase the number of bedrooms and shared spaces.

● The provider had some dementia-friendly signage in place. Following the inspection, we received photographs to show that bedroom doors had been painted in bright colours so that each person would know which was their bedroom.

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 Act 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Senior staff had assessed people's capacity to make decisions and most staff had a reasonable understanding of the principles of the MCA. They said they supported people to make their own decisions about the care they received.

● With the support of the local authority, the provider had recognised that not all staff had taken the MCA training fully on board and not all had the confidence to put the principles into practice. Further training, and support with carrying out assessments had been arranged.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection (under the previous provider) 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.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- We saw that people were not always treated with compassion and kindness. For example, we saw two staff hoist a person, who was quite distressed and hurting themself, without letting them know what they were doing and why. They did not reassure the person or speak to them at all, just spoke to each other the whole time. On two occasions they shouted at another person to sit down when the person stood up and called for help: the registered manager told us later this person shouts when they need to go to the toilet. At lunchtime a member of staff removed an apron from one person, from behind and without saying a word to them. They put the apron on another person, again without explaining what they were doing.
- Staff did not always respect and/or promote people's dignity and independence. At lunchtime a member of staff assisted a person to eat. They did not make the person comfortable in their chair. They gave the person far too much food in one spoonful and the second spoonful spilt onto their arm. The registered manager told us later that this person was able to eat without assistance once their food had been cut up. This meant the member of staff had treated this person in an undignified manner and had not promoted their independence.
- Staff did not always respect people's privacy. One person said they had never been offered a choice of male or female staff and staff did not cover them up during personal care. People told us staff did not knock on their bedroom doors. One person said, "As often as not staff just walk in without knocking." We heard this happen while we were talking with this person. The member of staff did not apologise, just said, "Oh, you're on the phone" and walked out. The person confirmed this was a regular occurrence.

The provider had failed to ensure that people were treated at all times with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One of the people we spoke with said staff treated them with kindness and they enjoyed banter and a joke with staff. All five relatives said they thought staff were kind and caring and treated people compassionately. One relative told us, "Staff are exceptionally hard-working." However, one person told us, "There are three to four carers who are nice, the others are only here for the money."

Supporting people to express their views and be involved in making decisions about their care

- Staff told us they supported people to make decisions about their care, but this was not very evident on

the day we visited.

● The registered manager told us they were introducing a 'resident of the day' scheme. Each day, two residents would be the 'resident of the day'. The senior member of staff had a long list of checks to carry out covering all aspects of the person's care. This included checking that care staff had reviewed the care plan. This did not indicate that the person or their relatives would be involved.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection (under the previous provider) 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.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Senior staff at Field House had been aware for some time that people's care plans were not person-centred and did not contain sufficient, up to date or accurate guidance for staff to be able to meet the person's current needs. Local authority staff had been working with the home's staff to ensure that care plans were improved.
- Care plans written by the deputy manager were personalised and reflected the care the person needed. However, only 10 care plans had been completed (less than 25%) although the local authority had been working with the staff for several months. Also, staff told us they did not have time to read the care plans and one member of staff said, "Sometimes there are not enough staff to complete tasks in a person-centred approach, like putting creams and perfume on."
- For most people and their relatives, all decisions about the person's care and treatment were made by the senior staff. One person said their friend helped them with their care plan. However, three relatives said they had never been involved in any assessment, care planning or review of their family member's needs. Another relative said "before covid" they were emailed a care plan review every month and "could let [the staff] know if they didn't like anything that was written." The fifth relative said they had not received anything since the initial care plan assessment, a number of years ago. Staff told us that they were not involved in writing care plans: care plans were written by senior staff.

End of life care and support

- Staff told us they had not had any training in end of life care. However, following receipt of the draft report, the provider told us that staff had received training on end of life care.
- The registered manager confirmed that at the time of the inspection there were no end of life care plans in place. She said that a person's relatives would be contacted if the person was at the end of their life. This meant that staff might not know what people's wishes were for the care at the end of their lives, so these wishes might not be fulfilled.

The provider had failed to ensure that people's care plans were fully person-centred, contained sufficient information and guidance for staff to meet the person's needs and contained people's preferences. This included plans for the end of a person's life. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider had made little attempt to ensure that information for people was accessible. Care plans and other documents such as the complaints procedure were not available in large print or any other format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider had installed a 'visiting pod' which meant that people could have a relative visit them and they were all protected by a perspex screen. The provider had allowed garden visits when this was within government guidance. However, they had been slow to comply with the guidance in March 2021, meaning that people had been deprived of having a relative visit them more closely for five weeks longer than the government deemed necessary.

● There were no activities taking place on the day we visited. Some staff did not have the time or the motivation to sit and engage people in an activity or even have a chat. We saw one member of staff standing leaning on the back of an armchair. They had been told to stay in the room with people, but they chose not to engage with anyone. Other staff told us they did not have time to engage with people; one member of staff said they stayed after their shift to sit and chat.

● The provider had employed two activities coordinators, but neither was on duty. The deputy manager said, "It's a shame you didn't come tomorrow. There would have been things going on." A relative told us, "There are lots of activities on FaceBook."

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure, which was displayed on a board in the hall. People and relatives told us they would speak with the registered manager or deputy manager if they had any concerns.

● Records showed that the registered manager had responded to a number of complaints within the timescales in their complaints policy. However, two relatives told us they had raised issues with the provider, but these had not been fully responded to nor resolved.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection (under the previous provider) this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- There was a registered manager in post. They were on maternity leave from February 2021 to 1 June 2021. The provider had promoted a team leader to the post of deputy and then acting manager. Although the local authority thought this member of staff was very willing to learn and "doing their best", they did not have the skills, knowledge or experience for this role. The provider had arranged some support for the acting manager but had failed to fully recognise their level of ability and that, because of staffing levels and staff performance, a lot of the acting manager's time was spent supporting staff by doing care tasks. The registered manager had been working part-time during their maternity leave to support the deputy (acting) manager.
- We found significant shortfalls in the quality of the service provided. Although the involvement of the local authority had mitigated some of the risk, improvements had not been made or sustained, demonstrated by some of the failings we found in the service. The registered manager told us, "Things are definitely not up to the standard I want them to be."
- The provider had not always fulfilled their legal responsibility to notify CQC about specific incidents.

Continuous learning and improving care

- The service was not well-managed and there were no systems in place to provide continuous learning and improvement in care practices. The provider lacked oversight of the service and had failed to recognise their responsibility to ensure that the service delivered to people gave them high quality, safe care. They had failed to recognise the importance of regularly monitoring all aspects of the quality of the service. The registered manager told us they and the senior staff carried out audits: there was no evidence that the provider checked their findings or reviewed whether actions to address shortfalls had been successful.
- The failures we found included: the failure to recognise and respond to concerns appropriately and in line with safeguarding policies and procedures; the failure to deploy sufficient staff with adequate training, knowledge and skills; the failure to ensure people were treated with dignity and respect; the failure to fully follow infection control and prevention guidelines; the failure to ensure that people received personalised care; and the failure to have a system in place to monitor the service and learn from incidents.

The provider had failed to monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person said, "The manager is nice here" and three of the relatives told us they knew who the registered manager was. They said she was "visible and approachable." Two of these relatives felt the home was well-managed.

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

● There was not a positive culture in the home. The registered manager was fully aware of this and was trying, with the support of the deputy manager, to turn this around. A member of staff had told us they had handed in their notice because "no matter how hard [the registered manager] tries to make changes, it feels like she's banging her head against a brick wall." They explained that staff did not take notice and/or did not care and behaved differently as soon as the managers were not around. This member of staff added, "The home is a disheartening place to work. To see the effort put in but things not changing."

● One person told us they were happy at Field House. Four people's relatives were happy with the care provided and said they would recommend the home if someone wanted this type of care. One relative said, "I would say the service is excellent" and another relative told us, "I can't fault the home, it is really good." The fifth relative felt the home could not meet their family member's needs and they were considering finding an alternative care home for them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Although we had not been sent all required notifications, those we had received indicated that the registered manager was acting on their responsibility to inform people and relatives when things went wrong.

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

● The registered manager told us that quality surveys were sent to people and relatives every six months so they could comment on the quality of the service being provided. However, only one relative recalled being sent a survey, which they had not completed.

● Staff meetings were held but staff did not feel their ideas or suggestions were listened to. Following receipt of the draft report the provider told us that a number of suggestions from staff meetings had been implemented. These included "set shift times, flexibility within shifts and meal time experience." The provider also told us, "[We have] also made a lot of changes to improve staff welfare …These include pay enhancement, paid breaks, formal contracts (not zero hour contracts), new uniform and badges, dedicated staff room with lockers etc, Xmas vouchers, recognition of good service."

Working in partnership with others

● The staff team worked in partnership with commissioners from the local authority and with health and social care professionals.

● Professionals who were supporting the home to improve the quality of the service provided to people felt staff, particularly the registered manager and deputy manager wanted to work with them.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's care plans were fully person-centred, contained sufficient information and guidance for staff to meet the person's needs and contained people's preferences. This included plans for the end of a person's life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated at all times with dignity and respect.

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 not always taken all reasonable steps to minimise the risks of spreading infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of abuse and avoidable harm as the provider did not have a robust system in place to protect them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy a sufficient number of staff who had the necessary skills, experience, training and knowledge to enable them to carry out the duties they were required to perform.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to monitor and improve the quality and safety of the services provided.

The enforcement action we took:

Warning notice served