Advent Estates Limited

Field Farm House Residential Home

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 farm House is a residential home that was providing personal care and to 64 people aged 65 and over at the time of the inspection.

People's experience of using this service:
The service was not well led. The provider failed to have sufficient oversight of the home and five breaches of regulations were identified.

Leadership and governance arrangements within the service were of concern, as they were not always identifying shortfalls and making changes to address them.

People who live at Field Farm House Residential Home were not always having their needs met by enough numbers of staff on shift.

Timely action had not been taken to address concerns regarding the environment. This placed people at risk of avoidable harm.

Infection control measures were insufficient and put people at unnecessary risk.

Support was not personalised and specific to the individuals needs and people were not always treated with dignity and respect. Staff had not completed training in dignity and respect and had not recognised situations which were undignified for people.

People's end of life wishes were not always recorded.

People's right to dignity and confidentiality was not always respected.

People were offered a choice of food and drink. However, people 's fluid and food intake were not sufficiently monitored therefore putting people at unnecessary risk of dehydration.

People and their relatives were encouraged to give feedback on the service, and areas for improvement through service user meetings.

Rating at last inspection: At our last inspection which was published 5 December 2016 the provider was rated Good in all areas.

Why we inspected: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions.

Enforcement: At this inspection, we identified breaches of regulation 10, 12, 15, 17 and 18. Full information

about CQC's regulatory response to any breaches of regulation found during inspections is added to reports after any representations and appeals by the provider have been concluded.

Follow up: Following the inspection we referred our concerns to the local authority. In addition, we requested an action plan from the provider, and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider 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 not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

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.

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 Farm House Residential 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.

Inspection team:
The inspection team consisted of one inspector, an assistant inspector, a specialist advisor [a [registered general nurse] and an expert by experience who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Field Farm House is a residential home for older people and people living with dementia. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (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;
This was an unannounced inspection.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority and we assessed the information in the provider information return. This is key information providers are required to send us about their service, what they do well, and improvements they plan to

make. This information helps inform our inspections.

During the inspection, we spoke with ten people who used the service, to ask about their experience of the care provided and four visiting family members. We observed staff providing support to people in the communal areas of the service using an observation tool called a SOFI. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This was so we could understand people's experiences. By observing the care received, we could determine whether they were comfortable with the support they received.

We spoke with members of six staff including the registered manager, deputy manager and care staff. We spoke with a visiting professional a district nurse, who regularly visited the service.

We reviewed a range of records about people's care and how the service was managed. This included looking at four people's care records and a sample of people's medicines administration records. We reviewed records of meetings, staff rotas and staff training records. We also reviewed the records of accidents, incidents, complaints and quality assurance audits the management team had completed.

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 in October 2016 we rated the provider as good in the domain of Safe. However, at this inspection we found people were not safe and were at risk of avoidable harm. Some regulations were not met therefore have changed the rating to Inadequate.

Using medicines safely.

● The storage of people's medicines was not always safe and so put people at unnecessary risk. We found that between the period of 01April 2019 and 10 April 2019 on the Robins Nest Unit storage of people's medication had exceeded the recommended temperature range to 32.2 degrees. No action was taken until the 10 April 2019 and the medications had still been administered to people. Medication should be stored between 15 and 25 degrees. If not stored properly they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. No advice by staff was sought from a pharmacist to see if it was safe to continue administering the medicines or if it was necessary to return and re order the medicines.

● We identified concerns about the way a cytotoxic medicine called Methotrexate was being administered. The toxicity of cytotoxic drugs means that they can present significant risks to those who handle them. Staff were not taking the necessary handling precautions to protect themselves and others, also by not using the appropriate storing and disposing procedures.

● In the medicine storage fridge, we found a container for storing urine samples. Keeping this type of urine samples in a medication fridge is not safe practice because it could contaminate any medicines being stored in there.

Assessing risk, safety monitoring and management.

● Systems in place to monitor and manage risks to people were inadequate. For example, people's care plans and staff handover information were not always consistent in providing staff with all the relevant information to ensure consistency in the care provided. For example, a falls risk assessment for one person stated the person was immobile in their care plan but this was incorrect because the person could stand with the assistance of staff or with their mobility aid. Their moving and handling care plan had not been reviewed since their admission to the home and therefore this added to the risk of the person receiving care which did not meet their current needs and was unsafe. We brought this to the attention of the deputy manager who told us they would amend the care plan promptly to ensure the person was cared for safely.

● Due to poor communication between the staff teams we found a referral to the district nurses had not been followed through when a person with a risk of pressure sores had been identified as having sore skin. There was a three-day interval from the identification of the sore skin and it was only acted upon when one of the inspection team brought it to the attention of the deputy manager, that this had not been followed up. As a result, the deputy manager made a safeguarding referral was made to the local authority.

Learning lessons when things go wrong.
● The provider did not have an appropriate system of monitoring all accidents and incidents in the home. We found they did not always put suitable control measures in place to mitigate the risk or potential risk of harm for people using the service. There was little evidence of learning from events or action taken to improve safety. For example, where people had fallen there had not been any referrals to the fall's clinic for further guidance to support people in reducing risks of injury.

Preventing and controlling infection.
● People living at the home were at risk and exposed to poor infection control measures. We found many examples of where staff were not reducing the risk of cross infections. These included soiled furniture cushions placed on the side of the bath in the communal bathroom. In the laundry we saw soiled underwear soaking in a container, rather than being washed in "red water-soluble bags" to prevent contamination. We found soiled incontinence bags left in the bathroom and one in the hallway. We saw soiled tissue paper left in an open top bin in one of the bathrooms. In one of the kitchens we saw a staff cloth apron screwed up and left on the floor. In the food store there was a motorcycle helmet left on the shelf next to people's food.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. Following this inspection, we passed our concerns about people's safety to the local authority commissioners for their awareness.

Systems and processes to safeguard people from the risk of abuse.
● Staff had received safeguarding training and understood what action to take in the event of any concerns for people's safety.

Staffing and recruitment.
● The provider used a dependency tool that was meant to indicate how many staff were to be used depending on the needs of people living in the home. However, the dependency tool did not recognise the needs of people living with dementia. We saw the current staffing levels did not meet the needs of the people living at the home. Some people required two staff to support them out of the three available on shift. Throughout the inspection we noted people were left unsupervised for up to 30 minutes in the Field Fayre Unit because staff were attending to people's personal care. We saw minor altercations between people, but no staff available to alleviate the tension created. At lunchtime we saw one person had to sit and wait for their meal until everyone else had been assisted for a period of 30 minutes.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

● The suitability of potential staff to care for people was checked prior to their employment.

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 our last inspection in October 2016 we rated the provider as good in the domain of Effective. However, at this inspection the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met. Therefore, we have changed the rating to Requires Improvement.

Adapting service, design, decoration to meet people's needs.
●The home was split into four units.

●Although people residing at the home lived with dementia, when we looked at the building and physical environment of the home we found this had not been adjusted to respond to people's needs. Most people living at the home were still mobile and enjoyed walking around the home and gardens. However, we found there was a lack of signs fitted to the bathroom and toilet doors, so people were provided with easy to understand information that are often helpful for people who live with dementia. Physical environment can assist people living with dementia by providing use of colour and lighting and signage to help people to find their way around.

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● We also found there were aspects of the provider's policies and procedures to ensure the home environment was suitably maintained were not consistently followed. For example, a door was left unlocked and had varied items, such as, cleaning materials and disinfectant which could potentially place people at risk. Some people enjoyed walking around their home and having these items in an unlocked room increased risks to their safety and wellbeing.

● We found access to the garden put people at risk due to uneven paths and hazards such as gardening equipment left out posing a potential fall hazard.

● We saw access to hallways and the communal lift was cluttered with equipment. We also saw communal bathrooms were being used to store equipment and missing radiator covers, all could potentially put people at risk.

● At lunchtime whilst a person was waiting for their meal a leg of the table fell off and the table landed in his lap. A staff member went to the person's assistance by retightening the table leg into position.

The above is evidence shows the provider had not provided suitable premises for people who lived at the home and is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and Equipment).

Supporting people to eat and drink enough to maintain a balanced diet.
● People's nutritional risks were not always managed effectively.

● For example, where people had been losing weight for several months. Their nutritional care plans did not offer any additional strategies to help combat this weight loss. There was no evidence it had been flagged with health professionals. When we asked staff, they could not tell us what action if any had been taken.

● Food and fluid charts were not maintained for those deemed at risk, these were not tallied and monitored. There was a lack of review of people's nutritional input.

● People were offered a choice of food and drinks and snacks were served during the morning and afternoon. People told us they enjoyed the food served.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs, and choices were assessed before they moved into the home. Staff felt they were given enough information to care and support people.

Staff support: induction, training, skills and experience.
● Staff told us when they started their employment at the home they were given an induction programme and the opportunity to shadow more experienced staff before carrying out duties unsupervised.

● Staff told us they received good access to training and felt supported by the management team.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
● We identified that staff did not work consistently with agencies effectively and this had impacted on the care that people received. For example, we saw there had been a delay in one person receiving pressure relieving care equipment.

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 with appropriate legal authority. 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 restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● The registered manager was aware of their responsibility to notify the Care Quality Commission of authorised DoLS. Staff we spoke with were aware of who was subject to a DoLS and what restrictions applied.

● Best interest decisions were in place where needed. These had involved suitable professionals such as healthcare workers and social workers. People we spoke with confirmed staff asked their permission before delivering any care. One person told us, "They [staff] knock before they come into my room and ask me if it's ok before they help me."

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 our last inspection in October 2016 we rated the provider as good in the domain of Caring. However, at this inspection people did not always feel well-supported, cared for or treated with dignity and respect, therefore, we have changed the rating to Requires Improvement.

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

● The overall valuing of people as individuals was compromised as the provider had failed to identify and act to address shortages of staffing, and the resources needed to maintain people's dignity. We saw one person walking around the communal lounge in soiled night wear. The inspection team had to request help from a member of staff to assist them. We saw another person left sitting in wet soiled clothing, whilst staff walked passed them, without offering assistance. When we asked a staff member to assist the person we were told "He's very difficult" and they continued to take them outside for a cigarette despite wearing wet clothing. Another person was walking around the home with their underwear over their trousers

● People's right to respect privacy was not consistently considered when staff communicated information about their needs. Staff used 'two- way radios' to communicate with each other throughout the home, but this allowed sensitive information about people's well-being and health, to be overheard by other people living at the home and visitors present. In one instance we saw a member of staff assisted a person with eating their meal with the radio placed in front of them on the dining room table and proceeded to communicate with other staff members.

● In the dining room of the Field Fayre unit we saw peoples' confidential care information left on the side for anyone to view.

The provider did not ensure people were treated with dignity and their privacy and right to confidentiality respected. This was a breach of Regulation 10 Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (Dignity and Respect).

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

● We saw people were able to make their own decisions about aspects of their personal care. For instance, if they preferred a bath or a shower.

● We observed and heard some care staff supporting people with a kind and respectful manner as they responded to people's differing needs. Some caring and kind interactions were observed during the inspection. It was clear some staff had developed good relationships with people, although due to the staff shortages staff were task orientated and had little time to spend talking to people.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection in October 2016 we rated the provider as good in the domain of Responsive. However, at this inspection we found people's needs were not always met. Regulations may or may not have been met, so changed the rating as Requires Improvement.

End of life care and support.
● People's end of life wishes were not always documented despite being identified as requiring end of life care. We heard one example where when we asked staff about the person's end of life wishes it was not clear whether the person had been asked. Therefore, staff could not be sure people's wishes were respected.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

● Daily recordings on the care and support people had received were not always fully completed. For example, people's weight charts where some people had lost weight over several weeks it was not clear what if any action had been taken.

● People's care and support needs were not fully identified and recorded in care plans. They did not include information about people's up to date care needs, or information about their preferences. Some people's records were inconsistent and provided conflicting information. This meant care plans did not provide staff with clear guidance on people's support needs. The registered manager told us they were in the process of changing to a new style of care plan which they hoped would be more person-centred. Although staff had shift handovers the information was brief and not fully up-to date. On staff member told us when they came on shift after days off they had to catch up with other team leaders to communicate any changes, throughout the day.

● Care plans were not always updated with information following changes in people's needs.
● The provider offered an activity programme of different interests which was displayed in the hallway to give people the choice whether they would like to attend. This included visiting entertainers to the home.

Improving care quality in response to complaints or concerns.
● The provider had a complaints process in place and people were aware of how to raise their concerns. We saw where a complaint had been raised the registered manager had responded in line with the provider's policy.

● The provider had not always followed the Accessible Information Standards there were missed opportunities to assist people with communication aids such as pictorial menus to help people make meal choices, calendars and activity programmes.

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 in October 2016 we rated the provider as good in the domain of Well-Led However, at this inspection we found there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met. Therefore we have changed the rating to Inadequate.

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

● There was a lack of audits, for instance monitoring information such as turn charts or nutrition charts. Infection control and health and safety audits had failed to identify the poor standards identified at the inspection. There were no provider audits to show they had taken place to identify shortfalls and monitor any actions required putting people at risk of harm.

● Medication management did not follow best practice guidelines. The provider had failed to ensure the system to monitor medicines administration was effective. The provider had an audit process in place, however this had failed to identify the concerns we found, a lack of guidance for administration and people's medicines were stored at the correct temperature, placing them at risk of harm.

● The provider had failed to ensure a system to effectively monitor accidents and incidents was in place. This meant there was no analysis completed to look for trends and enable action to be taken to prevent reoccurrence leaving people exposed to the risk of harm.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Continuous learning and improving care; Working in partnership with others.

● There had not been a staff meeting in the service since our last inspection, so staff had limited opportunities to discuss concerns with the management team. Handover meetings were held before staff shifts started so staff could be made aware of any changes in people's needs and issues to follow up.

● People and their relatives were involved in decisions through service user meetings.

● People had access to a range of other health and social care professionals such as district nurses, mental

health professionals, dentists, opticians, doctors and social workers in support of their needs.

● Relatives told us that the staff team communicated with them well and kept them involved in their family members care as much as possible. One relative told us how they had been informed promptly when their family member had fallen and required medical attention.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people where treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and wellbeing were managed safely. Medicines were not always managed in line with best practice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider has failed to ensure the good maintenance of the home to ensure people were not put at unnecessary risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of sufficient, competent staff meant people were not safe. The lack of support meant staff were not enabled to carry out their role competently

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
Treatment of disease, disorder or injury	The provider had failed to ensure robust governance systems were in place at the service. Records were not always up to date, and did not contain guidance for staff to follow about people's current care needs. Records which related to the management of the service were not well managed.

The enforcement action we took:

We imposed a condition on the provider's registration to restrict admissions to the home.