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	Requires Improvement

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

Summary of findings

Overall summary

About the service
Field House Residential Care Home for the Elderly (Field House) is a residential care home. The service provides personal care and accommodation in one adapted building to up to 49 older people, some of whom live with dementia. At the time of the inspection 36 people were receiving the service.

People's experience of using this service and what we found
Although no one had been harmed, action had not always been taken in a timely manner to keep people safe. Improvements were needed to fire safety and ensuring hot water was provided at a safe temperature. The quality assurance system had not identified these issues so that appropriate action could be taken in a timely manner. After the inspection the provider took action immediately to make the required improvements.

People living in the home and staff all spoke positively about the new manager and the changes they had implemented so far. Potential new staff to the service underwent checks to make sure they were suitable to work with people. Feedback was positive about the staffing levels in the home and people's needs were met in a timely manner.

Staff were following current government guidance around good infection control procedures. Medicines were being administered as prescribed. Written procedures were in place to advise staff when to administer "When required" medications. Accidents and incidents were being analysed to ensure that themes and trends were identified and the necessary action taken to prevent a recurrence and the recording of this was being improved.

Staff used their training knowledge to safeguard people wherever possible and support people to keep safe from poor care and abuse. If staff had any concerns about people, they knew where to report this both internally and outside of the service. Staff spoke favourably of the management team and stated that they felt supported in their roles.

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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 May 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found that although improvements had been made in some areas they were still in breach of regulations.

Why we inspected
We carried out an unannounced inspection of this service in March and April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and quality assurance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to fire safety and quality assurance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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.

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 Health and Social Care Act 2008.

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

Inspection team
One inspector carried out this inspection.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager was in post and

will be submitting an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with three people who lived at Field House, we also observed the care and support people received in communal areas of the home. We spoke with the manager, a manager from another of the providers home, senior care assistant, care assistant, housekeeper and the chef.
We reviewed a range of records including 3 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and a variety of other records relating to the management of the home, including polices and audits.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Not all risks to people had been reduced where possible. This put their health and safety at risk.
- There were no records to show when the last fire drill was carried out, when the fire points and emergency lighting was tested or when fire doors were checked. The new manager stated that a previous employee had carried out those checks, but they had left in June 2021 and no one had taken over the role. There were no means of safely evacuating people from the ground floor who could not walk down the stairs in the event of a fire.
- The information in the fire "Grab bag" to be used by staff and the fire service in the event of a fire, did not contain up to date information about who was living in the home and what support they would require to evacuate. The fire risk assessment was not detailed enough.
- Audits had identified that not all bedrooms had thermostatic valves fitted. However, action had not been taken in a timely manner to fit them.

We found no evidence that people had been harmed. However, the service had not ensured people received safe care and treatment. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and manager took action during the inspection to make the required improvements. A Fire safety professional was contacted and booked to attend the home two days later to provide support and guidance. The maintenance man ensured thermostatic valves were fitted in all occupied bedrooms.

Systems and processes to safeguard people from the risk of abuse

- People told us that they felt safe and that if they had any concerns they would talk to the staff or manager about it. One person told us, "I do feel safe here. [The manager] is lovely, she comes to check I'm alright."
- Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and

externally, such as to the local authority, police and the Care Quality Commission (CQC). Staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Staff received training in the MCA and had a good knowledge of what this meant supporting people. Action was being taken to ensure that when needed people had their capacity assessed and best interest decisions were in place.

Staffing and recruitment
● Staff were recruited safely. Appropriate checks including Disclosure and Barring checks (DBS) had been made to ensure staff were safe to work with people. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Through our observations and people living at the service told us that they thought there were sufficient staff on duty to meet their needs in a timely manner. People told us that they sometimes had to wait up to 15 minutes for a support but that this did not happen often.

Using medicines safely
● People received safe support with their medicines provided by trained staff.
● Staff recorded what support they provided on medicines administration records (MAR) for each individual. They also ensured information about prescriber's directions, was available in people's care documentation and adhered to. Medicines were regularly checked and stored safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider's approach to visiting aligned with government guidance. People were able to have visits from their friends and families.

Learning lessons when things go wrong

● Accidents and incidents were being reviewed to ensure any action needed had been taken. Although people's records showed that appropriate action had been taken this was not always clearly recorded on the accident forms.

● Meeting minutes showed that the new manager shared learning from accidents/ incidents and complaints with staff so that improvements could be made.

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

At our last inspection the provider had failed to identify what improvements were needed and to take the appropriate action. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvements had been made the provider was still in breach of regulation 17.

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

- The provider of Field House had not always identified the areas for improvements and taken action in a timely manner regarding people's health and safety.
- Although the procedures were in place to monitor the quality of the service these were not always being followed. Some audits had not been carried out competently. Although tasks were ticked as completed this was not always accurate and meant areas for improvement were not always identified.
- Action plans were not always in place to ensure when needed improvements were made.
- The provider and manager had not carried out checks related to fire safety that would have identified the improvements needed. For example, it had not been identified that fire drills had not been completed.

This was a continued breach. There had been a failure to assess, monitor and improve the quality and safety of the service being provided. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager with the support of a registered manager from another of the provider's homes had put new process in place to make improvements to the care and support being provided. New audits had been put in place and the manager was checking they had been completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The new manager told us they were passionate about providing a good service and making sure that

when people moved into the home it was an exciting new chapter of their life with a focus on what they could achieve. They had strong values and wanted to ensure that the service continued to improve.

● People living in the home told us that had seen many improvements in recent months and that the manager took the time to ask them about their care and ask if anything could be improved.

● The provider was conducting a survey with people, relatives and staff. A report and action plan would be published when all of the findings were reviewed.

● Meetings were held with staff, people and relatives to seek their views. Staff champions in different areas had been identified such as end of life care, pressure care and food and nutrition.

● All of the staff spoken to said they found the manager approachable and spoke positively about teamwork and the recent improvements.

Working in partnership with others

● Records showed staff engaged with a range of health and social care professionals

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

● The provider and manager were aware of their duty of candour and legal responsibility to notify the Care Quality Commission of any allegations of abuse, serious injuries or incidents involving the police.

● The manager was open and transparent to people and relatives when things went wrong.

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 How the regulation was not being met: The provider had failed to mitigate risks to people where possible. Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The quality assurance systems in place had failed to identify and make the improvements needed. Regulation 17 (1)(2)(b)