Somerset Care Limited

# Field House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

About the service
Field House Care Home is a residential care home providing personal and nursing care to 34 people aged 65 and over at the time of the inspection. The service can support up to 39 people.

Field House Care Home is laid out over three floors and divided into areas: Orchard View and the Main House. Orchard view provides accommodation for people living with dementia and is laid out over one level. There are bedrooms, toilet and washing facilities, a kitchen and lounge-diner. The Main House offers accommodation across three floors, provides toilet and washing facilities, a hairdressing room, two lounges and dining area. There are additional 'nooks' or areas where people can sit throughout communal areas in the home. All floors can be accessed by a lift and there is access to other areas in the home via a stairlift. People have level access to large gardens. The registered manager's office is adjacent to the main entrance.

People's experience of using this service and what we found
People told us they received support from staff who were kind. People's equality characteristics were met by the provider. The provider supported people to express their views and be involved with decisions about their care. Staff spoke confidently about how they would support people in a dignified way.

Care plans we reviewed were person-centred and people were supported to access information that was important to them. The provider ensured people were able to maintain relationships and people were supported to access relevant activities. Complaints were reviewed and managed appropriately, the registered manager maintained a log of compliments. People were supported to create treatment escalation plans (TEPs) and the provider was working to develop end of life care plans.

People received care that was effective; people's needs and choices were assessed and reflected in their care plans. Mobility assessments for people who used specialist equipment were not completed in line with published guidance. Also, they did not include all the information required by the provider's template. Staff told us they were supported to carry out their roles through supervision and training. People were supported to eat and drink enough. People retained 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. People told us they were supported to access the healthcare they needed.

People told us they felt safe. People received safe care; risks were identified and assessed, guidance was available for staff about how they could lower potential risks to service users. Staff spoke confidently about how they would identify potential abuse and what they would do if abuse was suspected or witnessed. The provider used a staffing dependency tool to deploy staff across the service in accordance with people's needs. People and staff told us they felt there were times when staffing levels in the home were insufficient. Medicines and creams were managed and administered safely. Recruitment processes were in place, these included checks with the applicant's previous employers and disclosure and barring service (DBS).

The service was well-led, there were governance systems in place to identify errors and omissions and the registered manager was aware of their responsibility to act in an open and transparent way. Staff we spoke with talked about people in a person-centred way and there was a clear staffing structure in place. The provider had built links with local organisations and worked in partnership with others to improve the experiences of people. People and relatives were provided with opportunities to feedback their experiences of the service.

Rating at last inspection: The last rating for this service was good (published July 2017).

Why we inspected
This was a planned inspection based on the previous rating.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

### Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

### Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

### Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

### Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

# Field House

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was undertaken by one inspector.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced. The second day was announced.

What we did before 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and one relative about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, assistant manager, senior

care workers, care workers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly visit the service.

Good

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

● We received mixed comments from people and staff about staffing levels in the home. Comments from people included, "Not enough staff at the moment - in the day - staff always answer the bell - sometimes it's quite a long time" and, "Not always enough staff - adequate at the moment - sometimes things go wrong." Comments from staff included, "Staffing needs improving - we seem to get bouts - we seem to be generally short staffed - if you have a resident who is not well or in bed - you need time to have a chat, we don't have that time all the time."

● We reviewed the rotas and spoke with the registered manager and area manager about the feedback we received. The provider used a dependency tool to assess people's needs in relation to staffing levels and how staff were deployed across the service. The rotas we reviewed showed that, overall, staffing levels were maintained in line with the assessment.

● We did observe two occasions when people spoke with staff about their needs and when the people's needs were not met. For example, we observed one person requesting a cup of tea. Staff asked the person to wait until they had supported a person to transfer. The person required two staff members to transfer using specialist equipment and there were two staff members available in Orchard View. This meant there were no additional staff to make the person a cup of tea. Thirty minutes passed and the person was not provided with a cup of tea and left the lounge, returning to their bedroom.

● The provider had identified that there was a period during each day when staffing levels needed to be increased. The provider was acting to increase staffing levels at this time.

● We reviewed three staff recruitment files. Each file contained relevant checks, for example, with the disclosure and barring service (DBS) and previous employers. Checks with the DBS are important as they prevent people who may be unsuitable from working in care. One file we reviewed did not include a full employment history, however this file had been completed sometime previously and since then the provider had recognised the need to change their policy to ensure a full employment history was requested from applicants.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. Comments from people included, "I am completely safe here" and, "The safety part of it is very good."

● Staff we spoke with told us how they would identify potential abuse and spoke confidently about actions they would take if abuse was witnessed or suspected. For example, one staff member said, "I would look for changes in mood, [the person] being withdrawn, checking for bruises - I would report to safeguarding and the registered manager

● Staff received safeguarding training and the provider worked with the local safeguarding team when it was appropriate.

Assessing risk, safety monitoring and management

● Risks to people's safety were assessed and guidance was available for staff. For example, the provider used the malnutrition universal screening tool (MUST) to assess people's risk of malnutrition or obesity.

● The provider looked at outcomes to ensure that risks were managed appropriately. For example, reviewing incidents of urinary tract infections as a potential indicator people weren't drinking enough.

● The provider managed environmental risks in the home by undertaking routine checks. This included ensuring window restrictors were in place to prevent falls from height.

Using medicines safely

● Medicines were managed and administered safely. This included having protocols in place for 'as required' medicines, ensuring refrigerated medicines were stored at the correct temperatures and working with healthcare professionals, for example the GP, to review medicines.

● People confirmed they received their medicines and topical creams when they should.

● The provider had recently worked with a pharmacist to introduce electronic medicines administration records. This meant staff could access medicines information on an electronic handheld device and search for specific information they needed.

Preventing and controlling infection

● The home was clean and free from unpleasant odours. We observed domestic staff cleaning the home on both days of the inspection.

● Staff had access to personal protective equipment (PPE) such as gloves, aprons and face masks. We observed staff changing their PPE in between tasks. This helped to prevent the spread of potential infection.

Learning lessons when things go wrong

● The provider reviewed individual accidents and incidents and was in the process of implementing a different system to improve how trends and themes were analysed in the service.

Good

# 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 this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- People's needs were assessed and their choices were recorded in their care plans. For example, people's preferred names were documented in their care plans and we observed staff calling people by their preferred name.
- When people were unable to transfer independently and required support from staff and specialist lifting equipment, guidance was not always produced in line with published guidance about best practice. Additionally, information required by the provider's manual handling assessment template was not always completed. For example, one person required specialist lifting equipment when using the toilet, under the assessment heading, 'Make, type and size of sling' the word 'small' was recorded, however details about the make and type of sling were not documented. The same information was also missing from assessments for bathing and transferring the person from the bed to the wheelchair.
- We spoke with the registered manager and area manager about the assessments and they confirmed they would review and amend them to ensure they were complete.

Staff support: induction, training, skills and experience

- Staff were supported to carry out their roles through training provision. The provider had recently introduced an online training platform. This helped staff to learn because they had easy access to courses and no need to travel. Certain courses, including manual handling training and first aid, were completed through blended learning: a mixture of practical and learning based sessions.
- The registered manager ensured staff received supervision sessions and appraisals. These sessions were used to review staff progression and helped staff to understand how well they worked with people in the home.

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

- People were supported to eat and drink enough. We observed staff supporting people who required additional help with eating or drinking. For example, one person required prompting to eat, so the staff member sat with the person and offered verbal prompts as required. One person required physical help with holding a cup, we observed one staff member sat with the person holding the cup to the person's mouth so they could drink.
- Tables in the dining area were well presented with table cloths and cutlery. This helped people to enjoy a dining experience.
- On occasions, the provider worked in partnership with a local bakery and supermarket. This meant people were able to enjoy different dining experiences. For example, the bakery had presented the home with a large baked roll and the supermarket had provided ingredients so people could enjoy an 'afternoon tea'

event.

● Staff working with other agencies to provide consistent, effective, timely care
● We saw evidence the service had contacted healthcare professionals, including the chiropodist and District Nurse, when required. We observed the District Nurse visiting during our inspection.

Adapting service, design, decoration to meet people's needs
● The home was adapted to meet the needs of people. This included lift access to floors above ground level and adapted bathroom equipment so people less able to mobilise could have a bath.
● People personalised their rooms, this included bringing in their own furniture, for example chests of drawers and beds. One person said, "I brought my own furniture."

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.
● At the time of our inspection there were four people living in the home who were subject to DoLS authorisations. The registered manager was aware of when applications should be made to deprive people of their liberty.
● Staff were working in accordance with the principles of the MCA and care plans guided them to. For example, one care plan said, "Staff to always assume I have capacity and support me in my decision making as required."
● Staff we spoke with talked confidently about how they ensured people were supported to make their own choices. Comments from staff included, "There are small things that you can do, like ask a person if they want sugar in their tea."

Supporting people to live healthier lives, access healthcare services and support
● People told us they were supported to access the healthcare services they needed when they needed them. Comments from people included, "GP came today if they [staff] want the paramedics to come they are good - they don't mess about."

Good

# 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 this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence

- Staff spoke confidently about how they respected people's privacy and dignity. Comments from staff included, "When you're providing care you shut curtains and doors, you knock on the door to people's rooms."
- Overall, interactions we observed between people and staff were kind and dignified. We did observe one interaction when staff discussed placing a towel on one person's lap. One staff member said to another staff member, "I'm going to put a towel on [person's] lap because [person] dribbles." The conversation could be overheard and was not dignified for the person.
- Care plans guided staff to support people to retain their independence and recognised the tasks people could undertake independently. For example, one person's care plan said, "I can eat and drink independently."

Ensuring people are well treated and supported; respecting equality and diversity

- People said they were supported by staff who were kind. Comments from people included, "Staff are very kind" and, "Staff go out of their way to be kind."
- The provider ensured people's equality characteristics were met. For example, one person's care plan showed they were religious and attended a religious service relevant to their religion. The service occurred monthly in the home.

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

- People were supported to express their views in different ways. Staff were involved in 1:1 conversation with people about their experiences of living in the home. For example, people's experiences of mealtimes and if they felt safe.
- People's care plans guided staff to respect people's views. One care plan said, "I can communicate and make my wishes known."

Good

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

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

- The provider ensured care planning was person-centred and reflected people's choices. For example, one person's care plan said, "I usually go to be at 6:30 pm, but occasionally I stay up later. Please make sure my call bell is in my hand at night. I like to be checked hourly."
- Care plans guided staff to support people to retain control of their care needs. For example, one person needed assistance with personal care. Their care plan said, "If you give me my flannel I am able to wash my face and hands but will need assistance with other areas."

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.

- People were supported to access information that was relevant to them. People had access to larger font and staff who could support them to read information.
- The registered manager told us that, in the past, one person had been supported to use a computer pad to type what they wanted to say.

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

- People were supported to access activities relevant to them. For example, one person was supported to do gardening, including painting the garden fence. We spoke to one of the activities' coordinators who said, "You know the residents, what they can do and what they enjoy doing - I think they enjoy most of what we do – we've got [service user's name] - won't join the group activities - but enjoys a game of dominoes."
- The provider used technology that supported people to maintain their relationships. For example, one person was supported to speak with their relatives using the internet and watch videos of their relative's wedding online.
- Staff in the home undertook fundraising, such as hosting bingo games, to improve people's access to activities away from the home. This meant people had the opportunity to visit local places of interest and had recently enjoyed a trip to local castle ruins.

Improving care quality in response to complaints or concerns

- We reviewed complaints the service had received since the last inspection. The registered manager responded to complaints appropriately.

● The registered manager kept a log of compliments the service received. One compliment we reviewed said, "Thank-you for all the help, kindness and care you are giving to [service user's name]."

End of life care and support

● The provider ensured people had treatment escalation plans (TEPs) in place where it was appropriate. TEPs include information about people's treatment options in specific circumstances.

● The provider had identified that people's end of life care preferences had not always been explored and were in the process of ensuring people had end of life care plans where it was appropriate.

Good

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- Staff spoke about people in a person-centred way. When asked about the 'best bits' of their job, one staff member said, "Working with the residents and working with the staff - you can make it fun - I enjoy organising things for [service users] and seeing them enjoying it." Another staff member said, "People get choice - sometimes they need encouragement but they are happy when they've done things - you have to work out the individual."
- Staff we spoke with said they could approach the registered manager if they needed to. Comments from staff included, "Overall it's not badly run - can speak to [registered manager's name] if needed" and, "I would say if I had concerns - anything really bad - I would report to [registered manager's name]."

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

- There was a clear staffing structure and job roles in the home. One staff member said, "When you come in you know exactly what needs to be done and when, everyone works as a team."
- The registered manager was proud the service had achieved a rating of 9.5 out of ten through reviews left by relatives and people who had received support from the service.
- All services registered must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been managed. We found statutory notifications had been submitted as required.
- The provider had a programme of quality audits and checks in place. These were used to identify shortfalls, errors and omissions and prompted the provider to undertake corrective actions.

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

- The provider allowed people and their relatives the opportunity to complete a questionnaire if they wished.
- The registered manager operated an open-door policy so people and their relatives could speak with the registered manager when the need arose. One relative said, "I haven't had need to complain, but if I wanted to ask [registered manager] something their door is open."
- The provider sent out a newsletter periodically. The newsletter outlined activities available in the home and included pictures of people enjoying the activities.

Continuous learning and improving care

● The provider shared learning through their services. For example, when issues or concerns were identified in other services this was shared with the registered manager so they could implement changes. One recent change meant care plans for people with certain health conditions, for example diabetes, included more comprehensive guidance for staff.

Working in partnership with others

● The provider worked with staff to raise money for the Alzheimer's Society by hosting a tea party for people living in the home and their friends or relatives.

● The registered manager was working with a local school on planning for a 'window silhouette project'. The project involved decorating a window and lighting it up, this created a silhouette for people to view.

● Local school children visited at certain times of the year, including Easter when they participated in a bonnet parade.

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 registered manager was aware of their responsibility to be open and honest when things went wrong.