FitzRoy Support

The Pastures

Inspection report

1-4 The pastures
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
The Pastures is a residential care home providing personal and nursing care and is registered for up to 13 people. On the day of our inspection visit it was providing care to 11 people with learning, physical and sensory disabilities.

The care home provides accommodation across three adapted bungalows. The service was undergoing a programme of renovation such as new floors, a new activities room and a new sensory room.

People's experience of using this service and what we found

Right Support: Model of Care and setting that maximises people's choice, control and independence

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.

Right Care: Care is person-centred and promotes people's dignity, privacy and human rights

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it. Staff supported people according to this guidance.

People received safe care from staff who knew them well and understood risks to their health and safety. People received their medicines as prescribed and staff reported and acted upon any errors appropriately.

There were enough staff to keep people safe and they were trained in areas relevant to people's care. Where agency staff were used, they received appropriate information and training in relation to people's care.

Staff followed protocols to limit the risk of a spread of infection within the home such as using personal protective equipment (PPE). Some areas of the home required more thorough cleaning.

We have made a recommendation relating to the cleanliness of some areas of the home.

The service manager was visible around the home and led by example, working closely with staff and

relatives. Relatives were involved with people's care and could speak with staff or management if they wished to raise anything.

There were checks in place to show how the service manager oversaw the quality of the service and they put action plans for improvements in place where required.

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 home was rated Good at the last inspection (report published May 2019).

At this inspection we found the service remained Good.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and risk management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We found no evidence during this inspection that people were at risk of harm from these concerns.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The pastures on our website at www.cqc.org.uk.

Follow up
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?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

The Pastures

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
The inspection was carried out by one inspector.

Service and service type
The Pastures 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. The Pastures is a care home with nursing. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a service manager in post who was in the process of registering with CQC.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with five staff members including the deputy manager, the service manager, the provider's support and development manager, a nurse and a senior support worker. People living at The Pastures were not able to discuss the care and support they received with us. We spoke with two relatives and observed care and support being provided in communal areas.

We looked at four people's care records and associated documents such as medicines records, and four recruitment files. We looked at management records relating to oversight of the service such as improvement plans, staff rotas, incident records and maintenance records.

Good

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 good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- Staff were confident in recording and reporting safeguarding concerns and had received training.
- The service manager reported concerns to safeguarding as required and notified CQC.

Assessing risk, safety monitoring and management
- 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.
- There were detailed records of assessments of people's capacity to make specific decisions. There were records of how decisions were made in peoples' best interests including who had been involved in the decision-making process.
- Staff understood risks to individuals well. These risks were carefully and thoroughly assessed, recorded and appropriately managed. Where people's care required additional input due to increased risk, staff put this in place.
- Risks in relation to the premises were managed and new systems were implemented following any issues. This included the implementation of a new fire alarm system.

Staffing and recruitment
- Staff were recruited safely. This included obtaining references and the Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions. The information helps employers make safer recruitment decisions.
- There were enough staff to keep people safe. However, staff reported a high number of agency staff working in the service, which meant at times it was difficult to allocate staff on a shift who both knew people well and had an appropriate skill mix.
- Staff reported that it was difficult for support staff to maintain the cleaning of people's bedrooms due to

supporting people with their care. An additional cleaner had been recruited and the provider was awaiting the employment checks so they could start work.

Using medicines safely
● Medicines were administered as prescribed, and any incidents relating to medicines errors had been recorded and reported appropriately. Staff were supported appropriately to improve practice following any medicines administration errors they made.
● Medicines were stored securely, stock checked regularly and kept at a safe temperature. Where this had become difficult due to excessively hot weather, nursing staff had sought advice from a pharmacy regarding specific medication storage.
● Where people were prescribed medicines to take 'as and when required' (PRN), staff had information about when to administer them safely.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home required more regular hoovering in some bedrooms. The bathrooms also required some updating and more deep cleaning. There was a sofa which had become damaged as the upholstery was torn making it difficult to keep clean.

We recommend the provider consider current guidance around infection control and prevention and take action to update their practice accordingly.

The kitchen and associated appliances appeared clean and items in the fridge and freezer were dated.

● 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 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.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● The provider followed current government guidance with regards to visiting. Visitors to the premises were expected to wear masks during visiting.

Learning lessons when things go wrong
● Staff recorded and reported incidents appropriately and the service manager reviewed incidents, taking

action to improve practice where possible.

● There was a process whereby the provider's management team further reviewed incidents and recommended any further action if needed.

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 our last inspection we rated this key question 'requires improvement'. At this inspection the rating has changed to 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

- A relative spoke highly of staff, saying they were, "Like an extended family, we always have a laugh and a chat. The office staff are brilliant." Another said they were, "Very caring."
- Relatives gave examples of how people had achieved good outcomes, such as putting on weight and being able to go out more when they began to live in the home.
- Due to the large number of agency staff being used, there was not always a consistent staff team and staff reported times when morale was low. However, relatives and staff reflected that people received person-centred care from knowledgeable core staff. Staff were allocated work appropriately, and detailed information being available about people's care.
- The provider took action to boost staff morale, such as a 'staff appreciation week' which had taken place the week before the inspection visit, which included treating staff to a barbeque, bouncy castle, pizza and a pamper evening. A staff member told us, "Staff were smiling and happy and it was really nice to see."
- Staff told us the service manager led by example by working on shifts when needed and being visible throughout the service.

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

- Relatives told us that any difficulties regarding the care of people, or incidents were openly discussed with them. The management team were open and honest about errors that had been made and were aware of duty of candour.

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

- There were checks and audits in place and the service manager acted when improvements were needed. However, more detailed checks of the cleanliness of people's bedrooms would benefit the home.
- There was a clear action plan which we reviewed; this showed recent improvements to the service had been made in various areas including care plan records, staff files and updating the environment.

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

- Many people using the service were not able to communicate verbally, and staff used alternative communication wherever possible, including some signing techniques and other visual aides to engage and

involve people.
● Relatives confirmed they had been consulted about their relatives' care and involved in decisions relating to work around the premises to improve the home.
● We saw from records that peoples' families were involved in their care wherever appropriate.
● Staff were confident to raise concerns and felt supported by the service manager.

Continuous learning and improving care
● The service's action plan is ongoing in order to continuously improve the service. We saw from incidents that there was a culture of learning from mistakes in order to mitigate risks in future.

Working in partnership with others
● The service worked closely with other organisations and healthcare providers in order to deliver appropriate care to people. This included other teams such as the learning disability team, the epilepsy team and speech and language therapists.