The Fremantle Trust

Farnham Common 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

This inspection took place on 13 and 14 June 2016. It was an unannounced visit to the service.

We previously inspected the service on 7 November 2013. The service was meeting the requirements of the regulations at that time.

Farnham Common House provides care for up to 50 older people and people with dementia. Forty nine people were living there at the time of our inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received positive feedback about the service. Comments included "I'm quite happy here," "People here care a great deal," "It's all very good. We have a lovely room and a nice outlook. What more could we ask?," "I like living here a lot because of the care I get. I like being here with people" and "I'm really pleased with the care. Mum's very independent and difficult, they've been really patient with her. They persevere with her. They've been really good, I can't fault them." Health and social care professionals also spoke positively about people's care. For example, one said the home was "One of the best ones in the area."

We found there were enough staff to meet people's needs. The home used robust procedures when recruiting workers, to make sure people were supported by staff with the right skills and attributes. Staff were supported through a structured induction, regular supervision and an annual appraisal of their performance. There was an on-going training programme to provide and update staff on safe ways of working.

People's needs were recorded in care plans. These were kept up to date to reflect changes in people's circumstances. Risk assessments had been written to identify the likelihood of people sustaining injury or harm whilst they received care. For example, through falls or where they were assisted with moving.

People were supported to keep healthy and well. They had access to healthcare professionals and received their medicines safely.

There were safeguarding procedures and training on abuse to provide staff with the skills and knowledge to recognise and respond to safeguarding concerns.

People were protected from the risks associated with unsafe premises. The building was well maintained. Equipment was serviced to make sure it was in safe working order. Evacuation plans had been written for each person, to help support them safely in the event of an emergency.

The service was managed well. The provider regularly checked the quality of care at the service through visits and audits. These showed the service was performing well. There were clear visions and values for how the service should operate and staff promoted these. Records were maintained to a good standard and staff had access to policies and procedures to guide their practice.

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.

People lived in premises which were well maintained and free of hazards, to protect them from the risk of injury.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk.

People were supported by staff with the right skills and attributes because robust recruitment procedures were used at the service.

Is the service effective?

Good

The service was effective.

People received safe and effective care because staff were appropriately supported through a structured induction, regular supervision and training opportunities.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in their best interests, in accordance with the Mental Capacity Act 2005.

People received the support they needed to keep healthy and well.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff protected their privacy.

People were treated with kindness, affection and compassion.

People were supported by staff who engaged with them well and took an interest in their well-being.

Is the service responsive?

Good

The service was responsive.

People's preferences and wishes were supported by staff and through care planning.

People were supported to take part in activities to increase their stimulation.

People were supported by staff who responded appropriately if they had accidents or their needs changed, to help ensure they remained independent.

Is the service well-led?

Good

The service was well-led.

People's needs were appropriately met because the service had an experienced and skilled registered manager to provide effective leadership and support.

People's care was monitored by the provider to make sure it met their needs safely and effectively.

People were protected from the risk of harm because the registered manager knew how to report any serious occurrences or incidents to the Care Quality Commission. This meant we could see what action they had taken in response to these events.

Farnham Common House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 June 2016 and was unannounced.

The inspection was carried out over the course of two days. One inspector, a specialist advisor and an expert by experience were present for the first day. The specialist advisor's area of expertise was the care of older people and people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted health and social care professionals who have contact with the home and the local authority commissioners of the service, to seek their views about people's care.

We spoke with the registered manager and seven staff members. We checked some of the required records. These included seven people's care plans, ten people's medicines records, five staff recruitment files and four staff training and development files. We looked at accident and incident records, a sample of policies and procedures and records of visits from healthcare professionals.

We spoke with ten people who lived at Farnham Common House and five relatives or other visitors. Some people were unable to tell us about their experiences of living at Farnham Common House because of their dementia. We therefore 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.

Good

Is the service safe?

Our findings

People were protected from the risks associated with unsafe premises. The building was well maintained. Appropriate measures were in place to safeguard people from the risk of fire. We saw emergency evacuation plans had been written for each person, which outlined the support they would need to leave the premises. There were a range of procedures in the event of emergencies at the service. For example, missing persons, disruption to the water supply and gas leaks. Equipment to assist people with moving had been serviced and was safe to use.

Risk assessments had been written, to reduce the likelihood of injury or harm to people. We read assessments on people's likelihood of developing pressure damage, supporting people with moving and handling and their risk of falling, as examples. We saw people were supported safely. For example, two staff carried out moving and handling manoeuvres where hoists were used.

Accidents and incidents were recorded appropriately at the home. We read a sample of recent accident and incident reports. These showed staff had taken appropriate action in response to accidents, such as falls.

People were safeguarded from the risk of abuse. The service had procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. The contact details for the local authority's safeguarding team were displayed on the office wall, for staff to refer to when necessary. We were able to see from notifications we received that the home made appropriate referrals to the local authority where they had concerns about people's well-being.

People were supported by staff with the right skills and attributes. The service used robust recruitment processes when it selected staff. Recruitment files contained all required documents, such as a check for criminal convictions and written references. We noted from their starting dates that staff only started work after all checks and clearances had been received back and were satisfactory.

Staffing rotas were maintained and showed shifts were covered by a mix of care workers and senior staff. A senior member of staff covered the home as a duty senior. They co-ordinated the shift to ensure, for example, all tasks were completed and that referrals were made to health and social care professionals where necessary.

We observed there were enough staff to support people. Staffing levels had been determined from carrying out dependency level assessments for each person. We observed people's needs were met in a timely way with call bells answered promptly. We saw staff managed meal times and other busy times of the day well, to ensure people's needs were met.

People's medicines were managed safely. We saw people were supported to manage their own medicines where possible. For example, some people applied their skin creams themselves, to remain as independent as possible. There were procedures to provide guidance for staff on best practice in managing medicines.

Staff who handled medicines had received training on safe practice and had been assessed before they were permitted to administer medicines alone.

We observed staff when they administered medicines at breakfast and lunchtime. We saw they did this in a safe and orderly way. Appropriate records were maintained to show when medicines had been given to people. These had been well maintained. Medicines which required additional control measures were only accessed and administered by senior staff.

The registered manager took action where staff had not provided safe care for people. For example, where errors had occurred. Records were kept of meetings held with staff following incidents of this nature, to determine what had happened and to prevent recurrence. Disciplinary proceedings were used where necessary.

The service had procedures for controlling the spread of infection. Staff wore disposable gloves and aprons when they provided personal care to people. Aprons were worn when staff served food or supported people at mealtimes. The service had been awarded a five star food safety rating when it was inspected by the local council.

We saw there were appropriate arrangements in place for the safe disposal of clinical waste. The building was kept clean and odours were well maintained. When we went into the laundry on one occasion, we found there was unclear separation of clean and soiled laundry. For example, a bag which contained soiled laundry was open and placed within a few inches of clean clothes. This was mentioned to the registered manager, who took immediate action to remedy this.

Good

Is the service effective?

Our findings

People told us they felt safe at the home. Relatives also felt people were safe at Farnham Common House and made comments such as "I know she's safe" and "She is safe" when they spoke about their family members' care.

We received positive feedback from healthcare professionals about how the home managed people's healthcare needs. One told us communication was good within the home and said it was "One of the best ones in the area." Another healthcare professional told us "They have oral care plans here, which we don't see in a lot of other care homes. That's good, because there is a proven link between poor oral care and chest infections." A third healthcare professional commented "They really dedicated their time to working with me. The carers were great. They engaged, they really knew their residents."

We observed staff communicated effectively about people's needs. Relevant information was documented in a communications book and handed over to the next shift. Daily notes were maintained for each person, to record any significant events or issues so that other staff would be aware of these.

People received their care from staff who had been appropriately supported. New staff undertook an induction to their work. Staff were also enrolled onto the nationally-recognised Care Certificate. The Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way.

A member of staff told us their induction included training on infection control, manual handling and equality and diversity. They said they felt very well prepared to work within the home and training was updated regularly. Another member of staff said "There is always training going on, and you are reminded if you do not attend."

Staff received regular supervision from their line managers. Records were kept of these meetings and showed staff met regularly with their managers to discuss their work and any training needs. This meant staff received appropriate support for their roles. New staff were subject to two probationary reviews, to ensure they performed to a satisfactory level before they were confirmed in post. Appraisals were undertaken annually to assess and monitor staff performance and development needs.

Staff received regular training to equip them with the skills and knowledge they required to support people safely. There was a programme of on-going staff training to refresh and update skills. This included moving and handling, fire safety, safeguarding and food safety. Further education courses were also encouraged, such as the Qualifications and Credit Framework (QCF) and Business and Technology Education Council (BTEC) awards. All staff were expected to complete a BTEC award in dementia care. Three staff had completed it so far and a further three had applied. Another member of staff had applied to study a level 3 diploma in health and social care. Two senior members of staff had completed level 3 awards in 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 were being met. We found the home had made appropriate applications to the local authority where necessary. For example, where people needed to be given their medicines covertly or they were unable to leave the building. One of the healthcare professionals we spoke with told us "I'm impressed" when they saw the home had made appropriate DoLS applications.

People's wishes regarding resuscitation were noted in their care plans. Where relevant, forms which authorised healthcare professionals not to attempt resuscitation had been signed by appropriate persons, such as GPs.

People were allocated a keyworker. This is a member of staff assigned to the person, who helps co-ordinate their care, liaise with family members and ensure care plans are accurate and up to date. A photograph of people's keyworker was kept in their room so they and their relatives could identify them easily.

People were supported with their nutritional needs. We saw mealtimes were unrushed and gave people time to enjoy their food at their own pace. People were given choices of food and offered further alternatives if these were not suitable. Cooked options were offered at breakfast time. Staff asked people if they had enough to eat and drink. We saw staff in one lounge put on some gentle music to accompany breakfast time. This created a calm atmosphere and people enjoyed their meal, they chatted with each other and staff.

People's needs in relation to eating and drinking were recorded in their care plans. Staff followed guidance from the speech and language therapist regarding appropriate consistency of food, to reduce the risk of choking. We saw staff sat with people at the table at lunchtime in one lounge. This made the meal a social occasion.

People told us comments such as "The food is very good here, you get generous helpings, seconds are offered, " "The food is quite good, it's tasty, " and "There's plenty of food, it's acceptable, it's tasty. Yesterday there was lovely lamb and baked potatoes."

People's risk of malnutrition was assessed using a recognised tool. Where people were at high risk of weight loss, we saw staff offered them additional snacks to boost their calorie intake. For example, biscuits, cake and fruit smoothies. We noticed in one lounge a snack bar had been added. This contained a range of high calorie foods such as crisps, biscuits and chocolate for staff to offer to people. Staff said they would let the manager or a senior member of staff know about people who were losing weight or whose appetite was poor. They said they would then take appropriate action.

We saw a visitor came in to support their relative at lunchtime. They told us "I come in to encourage her to eat better." They said this was their choice, rather than a concern that staff would not support the person.

The visitor said there were no issues concerning the person's eating. They added "Any problems, I let the staff know and they get the doctor in."

People were supported with their healthcare needs. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when people had been visited by healthcare professionals. The records showed people were routinely seen by their GP and district nurses, where appropriate.

The design of the building took into account the needs of people with a range of disabilities. This ensured the layout and equipment provided supported people to remain independent. For example, doorways and corridors were wide enough to accommodate wheelchairs and bathrooms and bedrooms had enough space for manoeuvring hoists and other equipment. There was a passenger lift between the ground and first floor. Sensory nodules had been fitted to grab rails in corridors, to assist people with visual impairments. There was level flooring throughout the building and around the garden, to enable people to move around safely.

We noted the lighting in parts of the building was quite dim, for example, in corridors and some lounges. This may have affected people's ability to read and their overall well-being. We mentioned this to the registered manager. They told us this had already been reported to the provider's property manager, for attention.

Good

Is the service caring?

Our findings

We found staff were friendly, hospitable and welcoming. We received positive feedback from people. Comments included "People here care a great deal," "I like living here a lot because of the care I get. I like being here with people" and "I'm really pleased with the care. Mum's very independent and difficult, they've been really patient with her. They persevere with her. They've been really good, I can't fault them." Other comments included "It's alright. It's OK. I'm well looked after," "It's excellent" and "The carers are very friendly, very caring and very kind and helpful." Other residents told us "Everyone's nice. The staff listen to me. The staff are good, you can have a laugh," "They've always been very nice to me" and "They're brilliant. The girls are always friendly, they're really good here. The carers don't seem to get stressed; there was a resident who kept calling out 'nurse' and they coped with it very well. They encourage the residents. I think they are really caring."

Staff were caring in how they supported people. They spoke to people as equals and their mannerisms were gentle and supportive. Appropriate humour was used to make conversation light-hearted and fun. Staff listened to people and showed genuine interest in what they spoke about. We observed one person who suddenly felt poorly. Staff dealt with this in a caring and compassionate way and gave the person the support they needed. A social care professional commented in one of their reports "I witnessed staff treating people with kindness, respect and patience. Some residents displayed genuine affection for certain staff members."

People told us staff were respectful towards them and treated them with dignity. For example, doors were closed when they were supported with personal care and staff knocked on their doors before they went in. We observed dignity was maintained when one person's dressing was changed. The member of staff and visiting nurses ensured the person was covered. The only visible area was where the dressing needed to be applied.

People had been supported to dress well and to wear accessories such as jewellery, if they wished. We observed staff painting people's nails and engaging in conversation in one of the lounges.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. We heard staff came to the office to speak with the senior member of staff on duty. They reported one person appeared in pain and distress when they were moved. The senior member of staff contacted the surgery to discuss pain relief with the GP. End of life nursing support was also being arranged, to ensure the person's needs were met.

Staff were knowledgeable about people's histories and what was important to them, such as family members, where they liked to go on holiday and any hobbies or interests they had. Staff spoke with us about people in a dignified and professional manner throughout the course of our visit.

Staff actively involved people in making decisions. This included decisions about meals, gaining consent before care was carried out and asking people whether they wished to join in the activities.

People's visitors said they could come to see their relative or friend as they wished. Visitors' dogs were also made welcome. We heard staff welcomed people's visitors and asked them how they were.

The service promoted people's independence. Risk assessments were contained in people's care plan files to support them to do as much for themselves as they could. We saw a member of staff walked with one person along a corridor to help them get some exercise. Other staff offered gentle encouragement when people walked to dining tables using walking aids.

Residents' meetings were held at the home. We read the minutes of the three most recent meetings. These included discussion about meals, activities, how people wished to be addressed by staff and whether they would like to undertake any housework tasks. They were also introduced to new residents and reminded of the complaints procedure.

Good

Is the service responsive?

Our findings

People had their needs assessed before they received support from the service. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care plans were personalised and detailed daily routines specific to each person. They contained information about the person's likes, dislikes and people important to them. Staff were able to describe to us the support needed for the people they cared for. They were able to describe person-centred care and knew it meant meeting people's individual needs.

Care plans had been kept under review, to make sure they reflected people's current circumstances, such as changes to their mobility. This helped ensure staff provided appropriate support to people.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded, to ensure people's progress was monitored. This included information about any changes to people's health and well-being such as poor diet, falls and when pain relief had been given.

People's cultural, religious and lifestyle needs were taken into consideration. For example, church services were held at the home to meet people's religious needs. One person told us they were a vegetarian. We saw the home provided vegetarian options at all mealtimes.

There were procedures for making compliments and complaints about the service. We saw the home had received numerous compliments from relatives and other visitors. Any complaints were logged and responded to promptly and appropriately.

People were supported to take part in activities. The activity programme was displayed around the building. It included carpet bowls, arts and crafts, coffee mornings, exercises, a knitting club and poetry readings. A company which supplied animals to visit homes was also due to visit. The home was taking part in the 'Fremantle in bloom' gardening competition. People who lived at the home had been involved in planting up the garden and containers as part of this competition. A hairdresser visited the home regularly and the service had its own salon.

We received mixed comments about activity provision at the service. Some people were positive about the range of things on offer, others felt more or different activities needed to be arranged. One person said "I need things to keep me occupied" and another said "I've got a lot of go in me. I just feel there's nothing I can do."

We saw trips out were arranged, such as to Brighton, a boat trip and shopping. Library books were also available at the home. We found some people, who had been keen readers, were unaware of this. We mentioned this to the registered manager, to follow up.

Four staff and four people who lived at the home were involved in choir therapy. This aimed to improve well-

being through singing. There was also a singing group at the home each week.

The home had items of reminiscence around the building. These included vinyl records, a typewriter, record player, sewing machine, wedding dress on a mannequin and pictures of film idols, such as Cary Grant. These enabled people to participate in reminiscence therapy and stimulated conversation. Parts of the home were in the process of a redecoration programme, therefore not all areas had reminiscence items on view at the time of our visit.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. A computer in a shared lounge had access to the internet, to enable people to communicate with friends and relatives on-line. We saw social isolation was also an area considered by the home when assessing people's needs. For example, a risk assessment was contained in one person's file to ensure they were offered opportunities to spend time away from their room, to engage with other people. Relatives told us the home communicated with them about their family members' well-being. For example, "If there are any changes they contact me straight away. I come and go whenever I want. They are very accommodating despite the rules and regulations" and "They are very good at communication."

Good

Is the service well-led?

Our findings

People were cared for in a service which was well-led. Farnham Common House had an experienced and skilled registered manager. We received positive feedback about how they managed the service. For example, a healthcare professional told us "Farnham Common House have been open and accommodating." They added "They did a really nice job of working with me." We asked a member of staff if the registered manager was open to new ideas and could they question practice. They said "Yes, I would feel ok questioning the manager and he's always open to new ideas." Other comments included "(The registered manager) is very responsive, he runs a tight ship effectively" and "(The registered manager) is doing his best to make it feel like a home."

The registered manager was aware of good practice and involved the home in projects to develop and improve standards of care. For example, they had used current good practice to change how they supported people at night time, in one part of the home. This included staff wearing pyjamas to reinforce the time of day. Staff told us this had resulted in some people being more settled at night and the incidence of falls had decreased. We saw the home was also taking part in a local project to improve communication about people's needs between hospitals and care homes.

Staff were supported through regular supervision and received appropriate training to meet the needs of people they cared for. We observed staff, visitors and people who used the service were comfortable approaching the registered manager to ask for advice or pass on information.

The service had a statement about the vision and values it promoted. It included values such as choice, fulfilment, autonomy, privacy and social interaction. Throughout our inspection, we found staff were promoting these values in the way they provided care to people. For example, people's right to vote in the referendum concerning membership of the European Union was taken seriously and postal votes had been arranged for people interested in voting. We also read minutes of a staff meeting where staff were reminded about promoting people's dignity, such as through ensuring their clothes were kept clean and that people were dressed appropriately. We observed they were doing this.

The home was aiming to develop its links with the local community. For example, it had offered the premises for a couple of groups to use and more volunteer workers were being sought.

The records we looked at were well maintained; all were located promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medicines. These provided staff with up to date guidance.

Staff were advised of how to raise whistleblowing concerns during their training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace. All staff questioned about whistleblowing knew what it meant and said they would be happy to 'whistle blow' if they thought something was wrong. This showed the home had created an atmosphere where staff could report issues they were concerned about, to protect people from harm.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The registered manager had informed us about incidents and from these we were able to see appropriate actions had been taken. For example, where people sustained injuries, deaths and where the police had been contacted.

People were protected from the risk of unsafe care. The provider regularly monitored the quality of care at the service through visits to the home and by audits of care practices. We saw audits had been carried out on, for example, medicines practice, safeguarding and safety, community links and infection control. We looked at the latest report of the provider's comprehensive quality audit, dated February this year. This reflected good standards of care were provided at the home. We also noted the home performed well in a 'mystery shopper' evaluation and scored ninety-one percent.

We found there were good communication systems at the service. Residents' meetings were held regularly. These provided an opportunity for communication between people who used the service and staff about concerns or improvements that were being made. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.